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Original Communications.

URETHRAL STRICTURE.*

By JAMES EDWIN DEDMAN, A.B., M.D.

BIRMINGHAM, ALA.

Perhaps no malady that male subjects are heirs to is of more vital interest than stricture of the urethra. Appalling for its frequency, insidious in its onset, painless in its formation, deceptive as to its extent, rich in its complications, frightful in its results, it becomes at once not only one of man's worst enemies, but through him, a menace to womankind.

In treating this subject, I shall confine myself solely to the discussion of specific urethral stricture, viz: gonorrhoeal, and not take into consideration strictures arising from other sources, such as traumatic and congenital strictures. Wossildo defines stricture as: "A narrowing of the urethral lumen and reduction of its normal dilatability produced by organic changes in the urethral walls." Taylor defines it as: "A condition of the canal attended by decidedly well marked contraction, or stenosis, and an utter loss of dilatability, caused by an inflammatory process which produces a sclerosis of greater or less density and contractile power."

Since we have excluded from this discussion congenital and traumatic strictures, we will proceed to the usual classification of strictures produced by specific inflammation in the urethral canal. This division would include (a) inflammatory (b) spasmodic (c) organic.

Any inflammatory condition existing for an extended period of time in the urethra may cause a stricture. I am also excluding in this discussion strictures that are caused by cicatricies from chancre and chancroids, and those that are the result periurethral

*Read before the Jefferson County Medical Society, Nov. 27, 1905.

neoplasms, since specific gonorrhoeal urethritis is the cause of nearly ninety per cent. of all cases of stricture. It is a most generally accepted belief that strictures are caused, not so much by the severity of the inflammatory process as by the length of time that the inflammation exists, and it has been my experience that in a large majority of cases, there is a history of repeated recrudescence of a primitive attack of gonorrhoea.

This classification of strictures into inflammatory, spasmodic, and organic, and the division of organic strictures into (a) those of large calibre, and (b) those of small calibre, is, to my mind, a misleading one. What is ordinarily termed an inflammatory stricture is simply a localization of the inflammatory process at some particular part of the urethra and an oedematous infarction either behind or in front, which is but an ephemeral condition, and will readily subside with the disappearance of the inflammation.

As Culver and Hayden put it: "If the term inflammatory stricture were dropped and we spoke merely of the actual conditions present in such cases, viz: an acute catarrhal inflammation, with recent soft exudation into the mucous and sub-mucous tissues, our nomenclature would be much simplified and improved."

As for spasmodic strictures, I believe that this condition should not be made a part of the classification of strictures, for the reason that a spasmodic stricture is nothing more or less than a reflex action of the muscular fibres of the urethra, which takes place in an attempt to introduce an instrument into the canal. The type of men that are exceedingly nervous and who are parallels to the hysterical type of women are those that this condition most usually exists in. It may be caused by an inflammatory condition of the urethra or prostate, or it may be caused by an irritation about the rectum, or, as a result of tape worm, ascarides, haemorrhoids, fissure, fecal impaction, or by long retention of the urine.

As to the division of strictures into those of large and those of small calibre, this too is misleading nomenclature as no definite calibre can be set down as to what would constitute a stricture of large, or of small calibre; for what would be a stricture of small calibre in an already small urethra (although caused by considerable adventitious tissue formation) would in a very large urethra be termed a stricture of large calibre, and hence looked upon as a very mild pathological process.

Before studying briefly the pathology of stricture let us look at the histological construction of the urethra. It is lined by a continuous mucous membrane, supported upon a sub-mucous tissue which connects it with the various structures through which it passes. This epithelium is of the columnar striated variety, supported

upon a cuboidal epithelium which lies upon the sub-mucosa, but as we approach the fossa navicularis the epithelial cells assume the squamous type. The mucous membrane is reflected into the various ducts of the glands which open into the urethra, viz: Cowper's glands and the prostate, and also the ejaculatory ducts. The urethra is a collapsed canal and its walls are constantly in contact, except during the passage of urine. At the end of the penis (the fossa navicularis) the slit is vertical, in the spongy portion it is transverse and in the prostate it is arched. Throughout the canal we find small racemose mucous glands and follicles—the glands of Littre, situated in greater part along the floor of the spongy portion—but in the roof of the fossa, one and a half inches from the orifice, is the lacuna magna, in which if care is not taken, small bougies may be caught.

The urethra is about 8 1-2 to 9 inches in length, and is divided into a pendulous or spongy portion, a membranous and a prostatic portion. The pendulous portion is about 6 1-2 inches in length; the membranous three quarters of an inch, and the prostatic one to one and a half inches. The pendulous portion is the seat of all strictures, except in very rare cases the pathological process may be so severe as to encroach into the membranous portion, and no one has ever, as yet, discovered a stricture of the prostatic portion.

As the gonococci are transplanted into the orifice of the urethra they are unable to penetrate the layer of squamous epethelium and travel backward until they reach the cylindrical cells—the time consumed in doing this representing the period of incubation, which varies from three to seven days. The rapidity here, however, will depend very largely upon the number of gonococci that enter the meatus at the time of coitus. In the early days of the infection, if we examine the discharge, we will find that it consists of pavement epethelial cells, some of which will contain gonococci and a few pus cells which do not, as yet, show any invasion of the cocci. Later on the epithelial cells become more thickly studded with the cocci, the pus cells are more numerous, but do not yet contain the microbes. Later the discharge consists almost entirely of pus cells loaded with cocci, and the germs may be also found floating free.

The pus cells of gonorrhoea are larger than those of any other form of suppuration, thus indicating that gonorrhea is a severe catarrhal inflammation, accompanied by an exudative inflammation in the sub-mucous connective tissue, and that if this continues for any length of time irreparable damage will result. There is an exudation of the cylindrical epithelium, and when this is replaced it is done so by the squamous epithelial cells. It is this cell proliferation that gives to the urethra in certain spots a granular appearance,

which can be plainly seen with the endoscope, and which has given rise to the term "Granular Gonorrhoea." There may be an ulceration in the connective tissue and morphological changes in the urethral glands. There is a round cell proliferation, not only on the denuded cylindrical cells, but into the crypts and ducts of the mucous glands. It is easy then to understand that the healing process of a specific urethritis must be necessarily slow, as all of this denuded epithelium must be restored, and squamous cells exchanged for the cylindrical, and the round cell proliferation absorbed.

Now, this inflammation, unless checked by vigorous therapeutic and prophylactic measures, will continue in a chronic form, and its longevity is very materially assisted by the mechanical and chemical action of the urine, the engorgement of erections, gravitation, the excessively vascular supply to the region, and the contact of the mucous surfaces with the resulting frictional irritation caused by exercise. When the disease becomes chronic, the denudation of the epithelial cells allows minute quantities of urine to penetrate the surrounding connective tissue, and in order to prevent this an inflammatory exudation is excited and dams of lymph are thrown out which become organized and form the ground work for what is termed a "stricture." At this time the infiltration may be quite succulent, and if it is in sufficient quantity to produce any diminution of the urethral calibre, it is termed a soft stricture. Later by an increase of connective tissue and absorption of the round cell infiltration, this may result in a very firm, unyielding stricture, which is termed "an inodular stricture." This may increase in extent so that it may involve not only a considerable portion of the urethra, but even the periurethral structure and may become so dense and inelastic as to bear a very close resemblance to cicatricial tissue.

The most usual location of stricture is at the bulbo-membranous junction, which can be accounted for by the excessive vascularity of this part, which intensifies the inflammatory gonorrhoeal process here, as well as by the effect of gravitation which favors chronic congestion. 320 specimens examined by Sir Henry Thompson, 67 per cent. were found at the bulbo-membranous junction, 17 per cent. within 2 1-2 inches of the meatus and 16 per cent. in the intermediate spongy portion. In 123 cases of specific urethritis in my own practice, and of which I have kept records, eighty of them were affected with stricture, 41 had posterior urethritis, and in two the inflammation never extended into the posterior urethra. In other words, out of 123 cases, 65 per cent. were strictured, 33 per cent. were not strictured (but were victims of posterior inflammation) and 2 per cent were confined to the anterior urethra only.

This large percentage of gonorrhoeics who become strictured as the result of this disease goes to show the great importance of carrying out a rigid course of treatment in every case and seeing that the "Donts" which are laid down by the surgeon are thoroughly carried out.

Included in my eighty cases of stricture are many who had been affected with chronic gonorrhoea for a number of years and came to me suspecting that they were strictured, or were sent by physicians who had already diagnosed them as such. Eight were life insurance subjects who had no inkling of the insidious pathological process going on in their urethrae, and whose urine was loaded with tripper faden, viz: pus shreds and mucous filaments. Out of these eighty cases four were patients who started treatment with me during their acute attack, and who when apparently well would commit some alcoholic or sexual excess and thus indefinitely prolong the inflammation. Of the forty-one cases of posterior urethritis thirty-two did not start any treatment until after five days had elapsed, and at this time the infection was tapping at the portals of the posterior urethra.

Taylor states that anterior urethritis in between 80 and 90 per cent. of cases passes backward and involves the posterior urethra. I believe that this is a very conservative estimate, but the great difficulty in obtaining reliable data on the subject is the varying times after infection that patients present themselves. In the two cases of mine where there was only an invasion of the anterior urethra, I saw them within forty-eight hours after the first symptom appeared. In the eighty cases of stricture just mentioned, forty-eight were at the bulbo-membranous junction (60 per cent.) twenty were within 2 1-2 inches of the meatus (25 per cent.) and twelve were scattered indifferently along the penile portion (15 per cent.). These figures vary but little from Sir Henry Thompson's report. As to the period required for the development of a stricture, it is quite hard to obtain reliable data, from the fact that it is difficult to ascertain just when the actual leakage of urine started. Some men may have a chronic urethritis for years and develop practically no stricture.

In a previous paper before this body I reported a case of chronic gonorrhoea of fifteen years standing, in which the urethra was but slightly abnormal. On the other hand, I have seen cases develop in from four to six months. Unfortunately, I have no reliable data concerning this in my cases, but I find eight cases in men past forty years of age and one case in a boy of eighteen which was of very small calibre.

Taylor says: "It is significant of the usual slowly developing character of stricture that the greatest number of patients applying for relief are between the 25th and 50th years."

It is beyond the scope of my paper to enter into a discussion of the various complications and sequellae of stricture, but in order to confirm my statement that it is a very serious matter, I shall mention the following most prominent ones: Peri-urethral abscesses which may result in urinary fistulae; prostatitis, which if the process be suppurative, is a grave condition; vesiculitis, cystitis, followed by hypertrophy of the bladder walls; dilatation of the ureters from urinary back pressure, this dilitation being so pronounced in some cases that on post mortem examinations the finger can easily be introduced into the tubes. Hydronephrosis, which being accompanied as it is in these cases by a general inflammation and by pathological changes in the ureters, bladder and urethra, which favor the introduction of suppurative micro-organisms, may become, sooner or later, the most serious complication with which we have to deal.

The subjective symptoms of stricture are first and foremost, a gleety discharge, which many authors claim is of rare occurrence, and Janin says: "Only occurred four times in sixty-one cases" While not constant, my experience is that 80 to 90 per cent of cases will exhibit a gleety discharge, never copious, and frequently absent during the day when it is being washed out constantly by frequent micturition—but the morning drop is always present, or can be expelled by ramonnage of the organ. Nearly every case will show mucous and epithelial cells or pus in the urine. I have yet to see a case of stricture without these threads in the urine.

Frequent micturition, brought on as Morrow says: "By a change in relation between the expulsive force required of the bladder and the accustomed demands upon it" is another symptom which appears later on in the course of the disease.

Frequent micturition is most usually caused by extension of the inflammation into the posterior urethra, involving the prostate or the vesical neck.

Divergence of the urinary stream, a burning sensation during and after micturition, increased muscular effort in the expulsion of the urine, neuralgic pains in the small of the back and inguinal region or spermatic cord, and vesical tenemus are other symptoms usually met with sooner or later. Oftentimes the first thing that will call the patient's attention to the presence of stricture is that it requires more muscular effort for him to expell the urine than formerly, and ere he consults the surgeon, vast pathological changes have already taken place, the formation of which has perhaps ex-

tended through a number of years, producing no symptoms that have called the attention of the victim to their presence.

As for the objective symptoms my main dependence is upon the endoscope. No means of diagnosis can be more positive than ocular demonstration with a well lighted modern endoscope, but considerable experience is necessary to differentiate pathological from histological conditions. In addition to this the urethramentre of Otis, flexible olivary bougies, the bougies a boule, a set of filiforms, Bank's whalebone bougies and a tunnelled catheter are valuable adjuncts in the armamentarium necessary for a scientific diagnosis, which can be made with great accuracy and precision, remembering that the points of greatest narrowness of the urethra are at the meatus, the middle of the spongy portion, and the membranous region, thus avoiding any danger of mistaking them for coarctations.

In determining the best course of treatment everything will, of course, depend upon the accuracy of the diagnosis. (a) The character of the stricture, whether it be succulent, semi-fibrous, or inodular; (b) its location; (c) the complications existing at the time.

With but few exceptions, nearly all of the cases which I have reported, were of the soft or of the semi-fibrous variety. The age of the patient will aid much in determining this fact; if he be under thirty years of age, the stricture is most likely to be easily dilatable, whereas, if he be between thirty and forty years of age, we would look for a semi-fibrous coarctation, and if past forty, he is likely the unfortunate possessor of the inodular variety. It is rare that patients under forty are troubled to any great extent with urinary retention, extravasation or dribbling. If the stricture is in the pendulous portion and of the succulent variety I use some form of dilatation, preferring rapid dilatation with some form of a modern dilator, such as Oberlander's or Kollman's and very seldom resort to the use of the steel sounds. Few patients can take more than two or three seances per week, and each time I carry them up two to four points in the French scale, keeping in mind the scale adopted by Otis, that for a penis measuring midway the pendulous portion three inches in circumference, the normal urethra should be about thirty French, and varying two points in the French scale for every 1-4 of an inch above or below this. After every dilatation, I use a hot intravesical injection, generally of albargin about ten grains to the quart of water, at a temperature of 110° Fah. or thereabouts. Frequently topical applications, such as silver nitrate 20 grs, to the ounce, iodosyl and glycerine or icthyol and glycerine are made to the stricture through the endoscope. Often I swab out through the endoscope the entire urethra with a solution of resublimed iodine, eucalyptol, tannate of glycerine and carbolic acid in a boro-glyceride

medium. In nearly every case I give some form of internal medication, calculated to act as an urinary antiseptic. For this purpose I use diuretin, salol or cystogen. Great care must be taken not to use violence and thereby increase the inflammatory process, and after the desired calibre has been obtained, the urethra should be carried up to this point once a week, for four or five times, and irrigation continued in the interim. With this method, I have had much success, and prefer it infinitely to any other in vogue. The advantage that I claim for dilators over sounds is that they are easier to introduce, as they can be put in as low as 18 French, and slowly carried up —hence are much less painful to the patient and will produce considerable less reaction. They are less apt to damage the urethra, as less force is required to introduce them, and it is very seldom that the meatus has to undergo a preliminary cutting, as is nearly always the case where full sized sounds are employed. If the stricture is at the bulbo-membranous junction, and of the inodular type, nothing short of one of the several methods of urethrotomy will attain the desired end. For internal urethrotomy the instrument of Otis is my favorite, but where the stricture is of very small calibre, the Maisson neuve instrument is indispensable, as it cuts from before backward through the stricture. I have often been able to use Otis' instrument instead of the Maissonneuve by passing a filiform through the strictured lumen and using this for a guide carrying down a tunnel sound, waiting a few days for the reaction to subside and then repeating the manipulation, using a larger sound, until the stricture was sufficiently dilated to carry the Otis instrument through it, and then cutting from behind forward. As for external urethrotomy, or combined internal and external urethrotomy, I prefer the Wheelhouse operation where the incision is made down on a grooved director, and thorough drainage of the bladder afterwards employed. In some cases this drainage is imperative, as it is the constant flow of urine over the stricture and leakage into the surrounding tissues that prolongs the inflammation and prevents the advancement of any repairative process.

I have heretofore reported several cases that have come under my observation, where men affected with stricture and ignorant of the fact married, and in course of time a reactionary inflammation set up about the seat of the stricture, gonoccoci which had lain dormant for years sprung into action and flared up an acute or subacute gonorrhoea, thus infecting the innocent wife. This question of gonorrhoeal infections in women is being discussed extensively by gynaecologists, but no reliable statistics have been compiled as yet showing the large number of pus tubes, inflammations of the cervix and endometrium which are the results of gonoccoci. It is time that

the profession, as well as the laity, begin to realize the gravity of every case of gonorrhoea and more thoroughly grasp its far reaching pathologic possibilities.

My idea in presenting this paper was to call attention:

1. To the large number of men affected at some time of their lives with gonorrhoea.

2. To the large percentage of these cases that through imperfect treatment, neglect, sexual and alcoholic excesses ultimately result in some form of stricture.

3. To the very serious conditions that accompany and follow in the wake of strictures.

4. To the necessity for a better and earlier diagnosis of stricture.

5. And for a more comprehensive and scientific treatment, thus avoiding the serious complications that are sure to ensue, and which may perhaps result either in death, or a protracted period of invalidism—to end which death would be a sweet relief.

UNCINARIA AMERICANA, AMOEBA DYSENTERIAE. AND TRICHOMONAS INTESTINALIS, CO-EXISTENT IN ONE CASE.*

By A. F. Toole, M.D.

BIRMINGHAM, ALA.

I have thought it might be of interest to report briefly a case in which there was found to exist a triple infection of intestinal parasites, two of them, the amoeba of dysentery and the hook-worm, being of considerable pathological importance, and the third, trichomonas intestinalis, being of lesser significance.

I am reporting both the clinical and microscopical findings through the courtesy of Dr. J. D. Heacock, whose patient it was, and who allowed me full privilege of noting the clinical aspect of the case, during the course of considerable microscopic work done to determine the diagnosis.

Mrs. J., white, about twenty-four years of age, and a native of Georgia, had been living in that state until about two months previous to her illness, moving thence to Birmingham. About four weeks before she was first seen, she began to suffer from constant headache, worse at night; she experienced likewise increasing lassitude, anorexia, nervousness, and dimness of vision, with some dyspnoea on exertion, and a feeling of palpitation of the heart. When seen by Dr. Heacock, considerable pallor was noted, with rather marked

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*Read before the Jefferson County Medical Society, Nov. 13th, 1905.

oedema of the ankles, and some puffiness of the face and wrists; her temperature ranged between normal and a degree and a half above normal; a careful examination, however, revealed nothing more, and the clinical picture was decidedly that of a nephritis, with consequent anaemia. Urinalysis, however, showed an absence of albumen and casts. Treatment was nevertheless instituted, appropriate for nephritis and particularly for the anaemia, but no improvement in symptoms was noted, except a disappearance of the oedema, which result might have been attributed to the rest in bed. A second urinalysis some seven or eight days later showed the slightest trace of albumen, but no casts. A complete examination of the blood was then undertaken, with the following results: Plasmodium of Malaria not found; hemoglobin, 65 per cent.; leucocytes, 6,000; erythrocytes, 3,500,000.

So far, as you can see, nothing more had been discovered beyond the microscopic determination of an anaemia which was already clinically evident; through it might be stated just here that the pallor of the skin was by no means extreme, nor was there observed any unusual tint; further, the patient showed no emaciation, and was living and had lived in circumstances above the average for those in whom hookworm is most often found, hence, probably, we had failed to connect the anaemia with a possibility of uncinariasis.

A differential count of the leucocytes was then made, and the following percentages were obtained: Lymphocytes, 21 per cent.; polynuclear forms, 54 per cent.; eosinophiles, 25 per cent.

This high percentage of eosinophiles was, of course, significant of something we had not yet discovered. It had been shown that uncinariasis is constantly accompanied by an eosinophilia, often of a high degree. Other and rarer conditions also show less of an eosinophilia, but the probabilities in this district pointed toward uncinariasis, hence I next examined the patient's stools. She had stated, I may say, that her "bowels were regular," but it developed later that such a statement was slightly incorrect and misleading, inasmuch as there had been in reality a mild diarrhoea. Under the microscope, numerous hook-worm ova were quickly found, but even before finding them, attention was drawn to two varieties of organism present in great abundance: one, with an amoeboid motion, tallied in all particulars with the amoeba dysenteriae, and could be so classified; the other, moving rapidly about by means of flagellae, was a less familiar object to all observers, but corresponded closely if not exactly to the trichomonas intestinalis, a parasite whose significance is but little understood. I had several other doctors examine the specimen, and all agreed as to the findings.

Treatment was then instituted by Dr. Heacock against the specific causes of the anaemia, and with a remarkable improvement in a short space of time; enemata of quinine solution being injected for the amoebae, and thymol being given by mouth to dislodge the hookworms. In addition, the cause being removed, iron was administered to combat the anaemia. I regret very much not being able to give the results of a later blood examination as to the hemoglobin and red cells, but the clinical cure was so pronounced as to leave no doubt as to the efficacy of the treatment.

I have attempted to discover some reports of similar cases in which more than one variety of pathogenic parasite had been found, but can meet with only one such report, and that merely by title. S. Osborne, about two years ago, published a case in which were found the three organisms existing in the case under discussion, and in addition detected the tricocephalus dispar, a fairly common parasite, apparently of no especial significance. In view of the fact that a careful examination of the foeces for any one of the organisms would most probably reveal the others, if present, I am inclined to believe that their co-existence is of rare occurrence. Simply as an example of such, the case stands as a medical curiosity, and nothing more; but there are brought forward by it certain rather interesting points for speculation and lessons as to the newer aids in diagnosis.

In the first place, it is interesting to speculate upon the extent to which the clinical picture as seen was modified by such a combination of causes; that is, whether certain symptoms, well-marked in a typical case of either disease when existing alone, might not have been neutralized, so to speak, by the presence of a second or third infection. The dysentery, for instance, should have been much more pronounced in a victim of amoebae to the number indicated by the microscope. The anaemia was likewise more in evidence clinically than would have been assumed from the blood-findings; and was possibly rendered more severe by the toxic absorption which might have ensued from two or more parasites, instead of one.

But the points of diagnostic importance are more positive; first, in that a differential count,—often, it must be confessed, of doubtful value,—did in this case point almost directly toward a hitherto unsuspected condition; and after a series of such findings in cases of uncinariasis, I am led to place a high value upon the presence or absence of eosinophilia, as determining the probability of a hookworm infection; and in cases where the foeces had not been or could not be examined, a differential count would be of decided assistance.

The second lesson, and one which fortunately is not often needed.

demonstrates the danger of being satisfied with a mere clinical history and picture, to the exclusion of other means of confirming the diagnosis. Had the doctor accepted the typical picture here presented as nephritis, the true etiology might never have been reached. Such a "snap-shot" diagnosis might of course have been gratifying, had it later been proven correct, but we know that when least expected one may develope into an unfortunate negative. The first findings, as to the urine, were discouragingly at variance with the clinical picture, but merely served to prompt perseverance until the true cause was found.

TUBAL PREGNANCY RESEMBLING APPENDICITIS.

By E. M. Robinson, M.D.

BIRMINGHAM, ALA.

Gynecologist and Abdominal Surgeon to St. Vincent Hospital.

Mrs. S., aged 28 years, mother of two (2) children, the oldest 4 years; the youngest nineteen months. The baby had been weaned four months. She had menstruated regularly for eight months, had menstruated last eleven days before beginning of present illness. The first symptom was sudden and severe pain which came during the evening of October 24th; I saw her at noon the next day with the following symptoms: Pain and tenderness at McBerny's point rigid abdominal muscles and vomiting. I made diagnosis of appendicitis, had her removed to St. Vincent's Hospital and operated at 4 p. m. for appendicitis. When the appendix was removed the evidence of disease was not sufficient to convince me that it was responsible for the symptoms, therefore I extended the investigation into the pelvis. Upon the right side I found a cystic feeling mass as large as a large lemon, this ruptured in my hand upon very slight handling and upon withdrawing my hand I brought out some very dark blood clots and the pelvis instantly filled with fresh blood. I now for the first time realize the true state of affairs. I at once drew out the tube ligated and removed it, mopped out the blood and blood clots and closed the abdomen without drainage. She made a quick and satisfactory recovery. The tube when examined presented an opening with ragged edges, this opening was about one inch from the fimbriated extremity.

I think it very probable that the rupture was caused by the corrosive action of the ovum, the inner coats were ruptured and the outer was ruptured by a mere touch.

In commenting upon an address of Prof. Minot of Harvard Medical School, upon this corrosive action of the ovum, Dr. Goffe of New York, has the following to say: "It has been discovered that certain tissues passes the property of attacking and destroying other tissues. This faculty consists in a process of digestion and is supposed to be chemical in character, from which the tissue itself does not suffer, but will destroy other tissue with which it comes in contact. The destructive process of the phagocytes is doubtless analogous. It is known that certain young tissues of the embryo are endowed with this capacity, and while it has not been absolutely demonstrated that the human embryo possesses it, the observation on the embryos of lower animals confirmed by the less complete studies of the embryo of man lead to the belief that such a phenomenon attends the implantation of the human ovum. The process of implantation as observed by Minot and others in various animals is as follows: The ectoderm of the chorion undergoes a peculiar proliferation by which its cells become much more numerous.

Some of the cells rapidly assume a distinctive character and are easily recognized by their large size. This layer of ectodermic cells is called by Minot the trophoderm. Wherever these modified ectodermic cells come in contact with the walls of the uterus, destructive changes go on in the uterine tissue, producing a cavity in which the ovum lodges itself. The trophoderm then undergoes a hypertrophic degeneration, producing a series of irregular spaces—which persist and become the intervillous spaces of the placenta. Papillary outgrowths of the chorionic mesoderm meanwhile penetrate the trophoderm, initiating the formation of the chorionic villi.

The effect of this corrosive action is rapidly conceived in cases in which the implantation of the ovum is transferred from the uterus to the thin-walled Fallopian tube. While in most instances the implantation is accomplished, there must be frequent instances in which the corroding process extends completely through the wall of the tube, or may bring the intervillous spaces so near to the surface that the blood pressure bursts through the peritoneum and occasions serious hemorrhage."

THE FUNCTIONS OF THE NERVOUS SYSTEM.*

By E. H. Sholl, M.D.

BIRMINGHAM, ALA.

My theme tonight, "The Functions of the Nervous System," is so broad that it can only be exhibited through the form of compact condensation, for it covers and dominates every energy of the human system from the first wail of the new-born babe to the last gasp that ushers it from the land of the dying into the land of the living. It expresses itself in the tear drop, it breathes in the fragrance of flowers; it takes in all melody from the song of the bird to the swelling of the diapason of the great organ; it views all beauties of nature and art that ravish the soul through the organ of vision; it discovers alike the atom and the remotest star; it is found in the blush of beauty upon the cheek of the maiden; by touch it opens a new world to blinded eyes; it revels in the delight of the palate and through the work of that great human alembic, the stomach, it transmutes the grosser material into the ruddy current whose flowing tide, in health, keeps pace with all the demands of human life. It builds empires and destroys them. It makes the earth a vale of gladsome beauty or a charnel-house. It guides the hand of the painter and sculptor. It chains the lightning as an obedient servant. It binds worlds together despite distance and perhaps by the awakening of a broad human charity shall precede the millennial period by a happy adjustment of forces now antagonistic, and realize in truth and in deed the common brotherhood of mankind—the dawn of that day whose elysian glories are only fully to be realized when the summation of all human problems that look to the elevation and purifying of the human race shall have its fruition in that land where sickness and sorrow and sighing and tears shall never come.

We come now to the matter of detail:

First. Cerebrum.—Seat of intelligence, will and reason.

Second. Cerebellum.—Co-ordination of muscular movements.

Third. Encephalic Ganglia.—Centres of consensual and emotional actions.

1. Optic Thalami.—Centres of common sensation.

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*Read before the Jefferson County Medical Society, Nov. 18, 1905.

2. Corpora Striata.—Centres of motion.
3. Tubercula Quadrigemina.—Special ganglia of vision, controlling optic nerve, iris, retina.
4. Olfactive Ganglia.—Special ganglia of smell.
5. Auditory Ganglia.—Special ganglia of hearing.
6. Gustatory Ganglia—Special ganglia of taste.

Fourth. Medulla Oblongata:

1. Serves to connect higher part of encephalon and spinal cord.
2. Presides over respiration, deglutition, aperture of glottis, laughing, yawning, sighing.

Fifth. Medulla Spinalis, Reflex:

1. Conductor of nervous agency (tubular or white matter).
2. Generator of nervous agency (vesicular or gray matter).

PHYSIOLOGICAL CLASSIFICATION OF NERVES.

First. Special Sense.—1st pair, olfactory; 2d pair, optic; 3rd pair, lingual or gustatory, glosso-pharyngeal; 7th pair, portio mollis or nervus facialis.

Second. General Sensibility.—Posterior roots of spinal nerves. 5th pair, 1st branch—Ophthalmic; 2d branch—Superior maxillary. 3rd branch—Part of inferior maxillary.

Third. Voluntary Motors.—3rd pair—Motores oculorum; 5th pair —Part of inferior maxillary branch; 6th pair—Abducentes; 9th pair —Hypoglossal—Anterior roots of spinal nerves.

Fourth. Involuntary or Respiratory (Bell).—4th pair—Pathetici or trochlearis; 7th pair—Portio dura or nervus facialis; 8th pair—Pneumogastric—1st pharyngeal branches; 2d inferior laryngeal (motor), spinal accessory, 1st external branch.

Fifth.—8th pair Glosso-pharyngeal.—Sensitive nerve of mucous membrane of fauces and base of tongue. Pneumogastric—Superior laryngeal.—Sensitive nerve of larynx; spinal accessory—internal branch.

NERVOUS CIRCLE OF THE FUNCTIONS.

Respiration—Excitors.—Afferent branch of 5th pair; afferent branch of pneumogastric nerves of general sensibility.

Motors.—Phrenic; intercostals; motor part of the pulmonary branches of the pneumogastric; portio dura; external branch of spinal accessory.

Deglutition (Entirely reflex).—Excitors—Afferent branch of glosso-pharyngeal; afferent branch of 5th pair.

Motors.—Pharyngeal branches of the pneumogastric; portio dura; hypoglossal; motor part of the inferior maxillary of the 5th pair.

Aperture of Glottis.—Excitor—Superior laryngeal of pneumogastric.

Motor.—Inferior laryngeal of pneumogastric.

Expression (portio dura).—Posterior roots of spinal nerves.

Touch.—Fibres of 5th and 8th pair and cerebral; pneumogastric and glosso-pharyngeal.

Taste.—Branches of 5th pair on upper face of tongue. Sensor—Glosso-pharyngeal on the lower part of the tongue.

Smell.—1st pair, olfactory.

Audition.—7th pair, portio mollis or nervus facialis.

Vision.—2d pair, optic.

REPRODUCTION.

First. Non-sexual: Fissiparous—Parent splits. Each part a new animal. 1. Transverse, as in hydra viridis (polypi); 2. Longitudinal, as in some verticella (infusory); 3. Irregular, as in gonicum pectorale (infusory); 4. Parent splits and discharges the young, as in votorx globator.

Gemmiparous.—Budding upon the parent stock as in hydra viridis; separated buds, gemmae, or sporalis. 1. On all parts of the body, as in the actinia medusae; 2. On one part or organ only, as in the aphrodite.

Second. Sexual.—1st, Hermaphrodite.—Both sexual organs in one individual; 1. Self-impregnation, as in some acephalae or holothariae; 2. On one part or organ only, as in the Aphrodite.

Deolcious.—Oviparous—Laying eggs which are hatched. 1. External fecundation; 2. Internal fecundation.

Ovo-viviparous.—Eggs hatched within the material body.

Mamiferous.—Suckling the young. 1. Monotrematous, as in ornithyorynchus; 2. Marsupial—kangaroo, opossum; 3. Placental or strictly viviparous.

HYSTERIA.

Dr. C. C. Hersman, of Pittsburg, Pa. (Journal A. M. A., November 11th) reports three cases, one of hysterical hyperpyrexia and two of motor (major) hysteria, one following a fright and the other a traumatism. In each there was only one set of muscles involved, in one the arm or leg and in the other the diaphragm. The attacks seemed to be unattended by fatigue, though violent and often of hours' duration, and attended with excessive perspiration. The cases suggest to him the following questions: Is there an irritating or paralyzing product formed within the cortical neurons? Is there an irritating body or product in the plasma bathing the nerve cell? Is there an increase in the formation of cytotoxins? Is there a decrease in the elimination of the metabolic waste product?

Society Reports.

Clinical Society of the New York Polyclinic Medical School and Hospital.

Stated meeting held November 6, 1905, the President, Dr. J. J. McPhee, in the chair.

SYRINGOMYELIA.

This patient presented by Dr. J. C. Lynch was an Austrian forty-four years of age, married, no children. Was perfectly well up to ten years ago last August, when she began to suffer from pain and weakness of the upper extremities on attempting to do any work. Her symptoms became gradually worse, and about five years ago her hands became deformed. This deformity is most characteristic, and at once suggests the condition from which she is suffering, syringomyelia. The condition is rare, and is due to cavitation of the spinal gray matter or a congenital dilitation of the central canal of the spinal cord, when it is known as hydromyelia, the analogue of hydrocephalus. Syringomyelia is usually the result of a neoplastic process or hemorrhage of the gray matter of the cord and the resulting secondary degeneration of the central portion gives rise to cavity.

The diagnosis of syringomyelia rests upon the presence of three characteristic symptoms. In this case, as in the majority of instances, all three are present. The existence of any one of the symptoms should excite suspicion, but the presence of any two makes the diagnosis possible.

These symptoms are: first, the disturbance of sensation known as Charcot's dissociated anesthesia, i. e., the loss of sensation of pain and temperature in any part of the body, with preservation of the tactile sensibility in the analgesic area; second, the trophic disturbances in the skin, muscles, bones or joints; third, the progressive muscular atrophy with the accompanying weakness. We also meet with associated conditions, i. e. spastic paralysis, disturbances of tactile senses with pain, transverse myelitis; mylitis involving the posterior columns of the cord; spinal deformities, eye symptoms, speech defects, bulbar symptoms, involvement of the cervical sympathetic, etc.

The patient presented is a typical clinical picture of this condition, the lesion being situated in the cervical portion of the cord. The symptoms depend upon the location and extent of the lesion

according to the anatomical paths in the cord, whose physiological functions are interfered with or impaired. On close inspection, marked wasting (atrophy) of the muscles of the thenar and hypothenar eminences of both hands, also of the interossi is observed, while overaction of the unimpaired muscles gives rise to marked deformity of the hands. The wrist joint of the right hand shows the characteristic deformity known as a Charcot's joint. The muscles of the forearm of the right side are wasted, while neither the left forearm or shoulder are involved.

There is well marked cervical dorsal kyphosis, while the dropping of both shoulders, with retraction of the chest produces the deformity known as Maries' thorax on bateau. The reflexes of the upper extremities are present, while in the lower extremities they are exaggerated, with extension response. There is no ankle clonus nor disturbance of the organic reflexes or of sensibility.

Bulous eruptions of the skin, herpes, perforating ulcers, shedding of the nails, hair, teeth, spontaneous fractures of the long bones and painful swellings of the extremities are occasionally met with in this condition. When pricked with a pain over the hands, forearms, arms and shoulders, the patient presented shows no evidence of pain, but when pricked anywhere below the mid-dorsal region in front or behind, she immediately jumps and cries out.

As to differential diagnosis, in a case so typical there is no danger of counfounding it with any other condition, excepting intraspinal tumor. If the case is seen early and the dissociated anesthesis is absent, it might be confounded with several conditions, of which pachymeningitis cervicitis hypertrophica stands first. This condition, Charcot's Jaffray's syndrome, is a chronic inflammation of the inner layer of the dura mater of the spinal cord, which is characterized by thickening of the membrane, which compresses the nerve roots and spinal cord, resulting in atrophy and sclerosis.

Syringomyelia runs a chronic course. It may progress slowly for years, or may remain quiescent, as in the case presented. No treatment is of any value.

GALLSTONES.

The next patient, presented by Dr. John A Bodine, was seventy-two years of age, the mother of a large family. She had suffered more or less pain in the region of her stomach all of her life, but had attributed it to indigestion, never at any time having been jaundiced. Pain became so severe that she consulted a physician a few weeks ago. A diagnosis of gallstones was made, but the speaker did not make up his mind whether or not to advise an operation because of the patient's age. Palliative measures were suggested.

Later, she demanded relief at any reasonable risk. When the abdomen was opened an appalling mass of adherent omentum and intestines was encountered. The line of cleavage was quickly found and the adhesion broken up. In a bed formed by the adhesions between the omentum, colon and liver, thirty-six large gallstones were found. There was no bile and not a trace of the fundus of the gallbladder. As soon as the last stone, which was impacted in the neck of the gallbladder, was removed, bile made its appearance. As there was no gallbladder to suture to the wound, the margins of the adventitious cavity containing the gallstones were sutured to the abdominal wound and a tube inserted for drainage.

This case illustrates the amount of destruction that may be accomplished with no symptoms other than those attributed to a long-continued dyspepsia; and it also shows that at seventy-two years the age-limit of the beneficence of general surgery has not been reached.

PARALYSIS OF THE FACIAL NERVE.

Dr. Bodine also showed a patient on whom he had operated five days previously for paralysis of the facial nerve. Twenty-three years ago the woman had had facial erysipelas, which was followed by facial paralysis. At present there was ordinary atrophy and flaccidity of the cheek, the staring eye and the mouth twisted over to the well side. An attempt to cure this patient seemed justifiable, as six cases had been reported in which the dead facial nerve was attached to a nearby motor trunk, and two patients had been cured. The best results, however, follow those cases of facial paralysis due to traumatism, as in mastoid operations.

The speaker said that he had not attempted an operation for a long time that was easier, technically, than the one he performed on this patient. The facial nerve in this case was represented by a mere fibrous cord, in which, however, some axis cylinder was discovered. The spinal accessory nerve was not utilized, for if it is not cut in two and an end to end anastomosis performed, every time the patient laughs the shoulder jerks. If the nerve is divided there is a troublesome atrophy of the shoulder muscles.

For anatomical as well as physiological reasons the motor nerve selected was the hypoglossal. The muscles of the tongue supplied by this nerve are in closer communication anatomically and physiologically than those of the spinal accessory, although the latter nerve is much more easily found and identified.

After the incision through the skin and superficial fascia, beginning at the level of the external auditory meatus and extending downward for two inches along the anterior edge of the sternomas-

toid muscle, one must be careful to separate the carotid gland from the anterior edge of this muscle without injury to its capsule, otherwise the carotid gland secretion will flow into the wound. Retracting the carotid gland toward the edge of the sternomastoid muscle posteriorly, one may readily identify the styloid process, and winding around its base is always to be found the facial nerve. It does not require five minutes to expose and identify this nerve. The transverse process of the second cervical vertebra is next identified, and just anterior to this, and posterior to the internal jugular vein, beneath or imbedded in the loose fascia, lie the pneumogastric and hypoglossal nerves. The positive identification of the hypoglossal is made by pinching it with thumb forceps or by electrical stimulation. Usually, however, the more superficial of the two nerves is the one in question. A split is made in the sheath or the hypoglossal nerve, and after cutting the divided facial nerve wedge-shaped, the latter is wedged into the slit and held by two sutures through the sheath, and the wound is closed without drainage. Up to the present the result had been good, but three or four months must elapse before permanent results would be apparent.

Dr. W. B. Pritchard said that a difference of opinion existed as to how long after paralysis occurs anastomosia could be attempted with success. The consensus of opinion is that it should be done within four or five years, as within this period of time the nerve to a certain extent is in an active condition.

The paper of the evening entitled

A SERIES OF INTERESTING PATHOLOGIC FINDINGS

was read by Dr. F. M. Jeffries. He said, in part:

In the study of anatomy one is impressed by the frequent departure from which is accepted as the standard. A vessel divides anomalously, an organ is misplaced, or there may be a total transposition of the viscera. We wonder at these unexpected variations more than when we encounter unusual conditions in plant life, because we feel that we can account for such alterations by some extraneous influence, the nature of which we may only surmise, or concerning which we must confess ignorance, or we may attribute them to the effects of hybridizing, or again to a natural reversion to the original type.

Throughout the entire practice of medicine one rarely encounters a disease which, so far conforms to its type in all its manifestations as to be classical. In some points it may be deficient, in others unusual phases are encountered. In animal and plant life we recognize the law that like begets like, each genus producing its kind.

This law remains unbroken even to the depths of the bacteriologic world. The laboratory worker, because of the nature of his work, encounters a goodly number of phenomena, and such collections are the more valuable because in many instances several years' subsequent history is available.

The first specimen I show you is a fatty embolus of the lung. Fatty emboli occasionally are produced after fractures, and after certain operations. A few years ago I was called to make examinations of certain organs to aid the prosecution in a case involving the care of an insane patient in one of the city institutions. The family of the deceased accused the hospital attendants of being responsible for the death of the patient. Two hospitals were in dispute as to the accounting for five fractured ribs discovered at autopsy. Those at the first institution at which the patient was confined declared that no ribs were broken when the patient left it; the others as strenuously asserted that he had no fractured ribs when he died, therefore the breaks occurred after death in the handling of the body. In court it was but necessary to convince the jury that fatty emboli could not be produced after death.

In the same set of organs a granular ependymitis was discovered. The ependyma is a very thin and delicate membrane lining the cerebral ventricles. Acute inflammation of this membrane in which small granular elevations are produced on the surface of the ventricles is nicely shown in the specimen.

The next specimen is adrenal tissue found in the kidney. This condition, while regarded as sarcomatous in character, is known as struma suprarenalis. I can only conclude that early in the embryonic state a bit of adrenal tissue, possibly only a cell, wanders away from its own and become enclosed in a kidney structure, where it remains dormant until some force acts to give it vitality, and it forth with begins to manifest itself by producing its kind. The specimen shown was removed by Dr. Ladinski was a woman 55 years of age. Her trouble dated from the beginning of her menopause, three years previously, so that this particular neoplasm remained dormant for fifty years or more when the physiologic processes of that period in the woman's life were sufficient to excite the foreign cell or cells to activity.

A still more striking exemplification of this wandering character of cells is shown in the next specimen, in which two nodules or apparently normal thryoid tissue were seen embedded in an otherwise normal lymph-gland. This was removed by Dr. Wyeth from the neck of a woman a few years ago.

A malignant adenoma, the structure of which is typical of pancreas, is the next on the list. This was removed from the abdomen of a child

nine years of age about a year ago. There were masses of this tissue everywhere in the abdominal cavity, which was greatly distended by their bulk. The child is still alive, but the growth is continuing, and at last accounts considerable trouble was being experienced in securing action of the bowels, and no hope was entertained for the recovery of the patient.

A peculiar form of sarcoma is the next specimen. This is from an infant, and was described as a large growth in the abdominal cavity. Its structure, whilst distinctly sarcomatous, is yet arranged in bodies which are, to say the least, very suggestive of malphigian bodies. The tissues came from Dr. Rolater of Oklahoma City, and no further history accompanied it.

Cancer of the appendix is rare. Primary cancer of the appendix is still more rare, and therefore primary cancer of the appendix in a girl fifteen years of age would hardly be expected. Yet such are the facts concerning the next specimen. The growth was situated at the tip of the appendix, and was not much larger than a grain of wheat. It was removed by Dr. Goffe five years ago. He says that the patient is still alive and in good health. The girl's family history makes mention of cancer in other members of the family. One would presume that the prognosis in this case should be good.

Endotheliomata are fairly rare, and most of these reported are associated, in their origin at least, with endothelial membranes. An endothelioma of the jaw is here shown. It is from a man 39 years of age, and is described as a tumor of the jaw the size of a hen's egg. It was attached to the left submaxillary triangle, and was of two year standing. It was removed by Dr. Bodine, and the patient is still alive and in good health, although three years have elapsed since the operation.

Many other unique and interesting specimens were exhibited and their histories given, the last three being an epithelioma from a horse, carcinoma from a dog and a sarcoma from a canary bird.

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Selected Articles.

THE STARVATION DIET.

By Emelyn L. Coolidge, M.D.

Visiting Physician to the Out-patient Department of the Babies' Hospital, and Physician in Charge of the Babies' Clinic of the Lying-in Hospital, New York..

As summer draws to a close and the babies begin to return to the city the pediatrist sees a pitiful set of cases almost as peculiar to this season of the year as are the summer diarrheas to the heated term or the pneumonias to the winter months; these patients I think may be justly termed "the starvation diet cases."

The history in nearly all instances is very similar; at some time during the summer the child has had an acute attack of diarrhea, just what variety it is usually impossible to learn from the mother's statement, the baby generally being a bottle-fed child on either a proprietary food or a high per cent. cream mixture. The country doctor called to treat the child has evidently been trying to keep up to date by reading the medical journals and has gotten it firmly fixed in his head that diarrhea in any form is the signal for stopping all milk and giving a cereal gruel of some sort; he has not been contented with doing this for a few days but has continued it week after week or has added a little whey to the gruel or possibly a small amount of top milk. He tells the mother that "Baby cannot digest milk and will die if put on it." The child grows weaker and thinner and more anemic until the mother, becoming much alarmed, determines to return to the city and consult a "specialist."

The general appearance of all these little patients is also much alike; the thin, pale child with depressed fontanel, sunken eyes and flesh hanging in folds, showing all too plainly the great loss in weight, keeps up a pretty constant fretful wail, drops off into short naps only to wake in a few moments, has restless nights and is generally a most miserable little specimen of humanity.

Now, the mistake made by these well-meaning men lies not in the fact they have placed the child on a gruel and omitted milk (for no treatment could be better for a few days), but in their inability to judge of the proper length of time that this treatment should be continued, in their keeping it up so long that the baby loses ground which it may take him weeks and even months to regain.

Unfortunately no exact period for the purely cereal diet can be set, as this depends on the individual child and on the variety of in-

testinal disorder present, but in the average case of so-called "summer complaint" after the intestines have had a thorough clearing out by means of castor oil or calomel and milk has been omitted for 24 or 48 hours, the temperature at the end of this time will drop and the stools begin to show some improvement, this is the time to gradually add a little milk to the cereal, and not top milk or cream which will so frequently provoke a relapse, but whole milk with the proteids predigested if necessary by means of a peptonizing agent. Only one-half or at the most one ounce of milk should at first be added to each pint of the cereal, then the amount increased as rapidly as possible until the child is taking a formula suited to his age and the peptonizing discontinued if this process has been used. It is a well-known fact that fats can not be borne in warm weather as well as in cold, so why expect the baby convalescent from an attack of summer diarrhea to take cream (often used as a laxative), when he may be given whole milk with the curd predigested for a short time if necessary?

The following are two of the many post-diarrheal starvation cases seen during the past few years, serving to illustrate what has been said above:

M. R., aged eleven months, never nursed, but fed on a "cream mixture" up to nine months of age, when patient had an attack of summer diarrhea with frequent thin, green stools and a temperature varying from 101 degrees to 103 degrees F. for two days, treated by a general practitioner who gave castor oil, then barley-water, which he continued for nearly two weeks; at this time he added a small quantity of whey, gradually increasing the amount in proportion to the barley, until at the time when I first saw the child she was taking about two-thirds whey to one-third barley. The patient was steadily and rapidly losing weight; very constipated, with marked anemia, sleepless nights and fretful days. The family physician absolutely refusing to change the food, the parents decided to consult a specialist. The little patient when first seen was taking her bottle in a ravenous manner, screaming for more as soon as it was emptied, then keeping up a pretty constant wail until next meal time. The scales possessed by this family were unreliable, so the weights taken were valueless. The patient was put on a formula consisting of fat one per cent., sugar five per cent. and proteids one per cent., the milk being peptonized one hour, then added to dextrinized oatmeal gruel made from the health food flour, seven ounces q. three h. This was continued for two days, then the formula increased to a 1.50-6-1.50. After three days more 2-6-2 was given, peptonized for half an hour. The child's stools were now perfectly normal; she slept all night, but

at times seemed hungry during the day; after three days more the interval of meals was lengthened to four hours, amount eight ounces, peptonized fifteen minutes, and between two of these meals beef-juice given, beginning with half an ounce and working up to one and a half ounces, between two of the other meals farina cooked very thoroughly in milk. At the end of another week the child's improvement was most marked; she was gaining rapidly in weight, although no exact data could be kept; stools were normal; anemia much less marked. The formula was now increased to 2.80-8.10-2.45, and the peptonizing discontinued; half a coddled egg was given in place of the beef-juice twice a week. There were no set backs and the child steadily improved, until, at the age of thirteen months she was taking plain, undiluted milk and other food suited to a child of her age.

Baby H., aged eight months, first seen the third week in August, when the mother had returned to the city from the country, as she "wanted Baby to die at home." The child had previously been fed on one of the prepared foods, and since his fourth month on a top milk mixture, the milk being taken from the tops of two bottles of milk. This was continued until early in July, when he became ill with what his mother called "cholera infantum." At this time he was a plump, well-nourished child, but had vomited some ever since hot weather began. A local doctor in the country village was called. He gave the baby castor oil and put him on albumin- water, which he continued for a week; he then ordered farina gruel made with water only. The movements improved, but the child grew steadily thinner and weaker; so after another week he tried barley gruel with a little cream taken from the tops of two bottle; the baby's temperature went up, the stools became thin, green and had some mucus. Castor oil was again given, and granum, made as thick as the child could possibly draw it through the nipple, used for food. This was continued until the third week in August, when all hope of saving the baby was abandoned.

When I first saw the child he was the picture of this class of cases. The emaciation was marked, weight being twelve pounds, great prostration, fontanel sunken, also the eyes, all mucous membranes were very pale; there was a constant hungry wail, except when the child dropped into a short nap, only to awaken in a few minutes; the stool seen was a typical granum movement, fairly thick, yellow, rather frothy and with a little mucus.

Treatment given was: Liquid peptonoids one drachm, q. three h. in one ounce water between meals; and for food a 50-5.50 completely peptonized added to granum made one even teaspoonful to the pint of water; six ounces of this q. three h. Three days later the baby

had gained eight ounces in weight; the stool seen was smooth and yellow, no mucus; he was much stronger and brighter; slept well at night, but cried when bottle was taken away in the day-time. 1.50-6-1.50 peptonized was ordered. When seen three days later the child had gained seven ounces more, was bright and playful, fontanel normal condition, stool normal; a 2-6-2 was ordered and one meal each day of mutton broth three ounces. When next seen, four days later, the patient had gained five ounces more, color markedly improved, stool normal, took long nap in day-time as well as sleeping all night. This time the food was not strengthened, but quantity increased to six and one-half ounces, and peptonized one hour only. At each succeeding call the food was gradually strengthened and time of peptonizing decreased until, at the end of four weeks after treatment was begun, the patient was taking eight ounces of unpeptonized milk, two-thirds and granum one-third, every three and one half hours. He was gaining at the rate of six to eight ounces a week, and in a normal condition in all respects. During this time he had cut two lower central incisors with no trouble. I feel confident that if this child had been given a high percentage of cream mixture, one attack of diarrhea would have succeeded another, or if he had been kept on a cereal only, death would have soon resulted from starvation; but when a mixture was given containing a low percentage of fat and predigested proteids he was perfectly able to assimilate the food and make a rapid recovery.

ROUTINE PROCEDURE OF THE CLINIC FOR THE TREATMENT OF COMMUNICABLE PULMONARY DISEASE OF THE DEPARTMENT OF HEALTH.

John S. Billings gives a description of the routine procedure followed at the Tuberculosis Clinic of the New York City Department of Health. This was opened March 1, 1904, and has been a success from the start. The clinic is open daily, except Sundays and holidays, from 9 a. m. to 4 p. m. and from 8 to 9 p. m., classes being conducted morning, afternoon and evening. The class on Tuesday, Thursday, and Saturday evenings is limited to colored patients, colored physicians being in attendance. The author describes in detail the various features of the manner of conducting the clinic, noteworthy elements of which are the routine throat and x-ray examinations that are made and the supervision over the patient's home life that is exercised by the regular visits of a trained nurse. The method of history recording and filing, prescribing, etc., are all explained; as well as the duties of the different members of the professional and lay personnel of the clinic.—Medical Record, December 16, 1905.

Abstracts.

MONTAIGNE ON THE PHYSICIAN.

It has been astutely observed by one having large insight into human nature, that the reason why the works of Montaigne endure and are perennially read, is that they furnish delectable pastime for idlers. Such idlers who read certainly do make up a proportion of humankind quite large enough to justify oft-repeated editions of these classics. Nor indeed is there any literature conforming better to a summer morning under the trees, with a land and water-scape upon which one may now and then raise his eyes from the pages.

It is in such atmosphere as this that one may best appreciate Montaigne. For it was thus that he wrote, in a rural environment, far from the seething and tumultuous life of his period—life nearly as strenuous as that of our day. And it is in this vacation spirit that this editorial idler has been browsing upon these essays. That on the physician contains some observations slightly foreign to the amiable tone which otherwise pervades these writings. For Montaigne had a decided grudge against the Faculty of his time, because they could not, or did not, relieve him of his stone in the bladder. True, Ambroise Parre might have done so, but then surgery in those days hurt; and Montaigne's nature was not of the stuff to endure without anesthesia the acute pain of such an operation. So he continued, although he was "very sensible of acute and corporal pains," to endure his stone, blaming the doctors for his sufferings until he died of its effects; and he valued life and health highly, declaring that "health is a precious thing, and the only one, in truth meriting, that a man should lay out, not only his time, sweat, labor and goods, but also his life itself to obtain it, for as much as without it life is injurious to us. Pleasure, wisdom, learning and virture without it wither away and vanish, and in the most quaint and solid discourses that philosophy would imprint in us to the contrary, we need no more but oppose the image of Plato, being struck with an epilepsie or an apoplexy; and in this presupposition to defie him to call the rich faculties of his soul to his assistance."

The impression one gets in reading Montaigne is that there is decidedly nothing new under the sun; here, for instance, we come upon a number of pleasantries which our comic writers would have us believe are originated by them. But bless you, they are all to be found in Montaigne, who, with a probity foreign to the morale of the present day jokesmiths, accredited them duly to the writers of antiquity. For

instance, a gentleman of the name of Nicoccles (a cotemporary of Plato) observes: The physicians "have this advantage, that the sun gives light to their successes, and the earth covers their failures." Again: "A physician boasting to Nicocles that his art was of great authority; 'It is so, indeed,' said Nicocles, 'that it can with impunity kill so many people.'"

Of Diogenes (the same old vagabond of disreputable memory, these twenty-five centuries past) there is this: "A poor wrestler turned physician. 'Courage,' said Diogenes to him, 'thou hast done well, for now thou wilt throw those who have formerly thrown thee.'"

Aesop (yes, the same old Aesop) offers the following: "A sick person, being asked by his physician what operation he found of the potion he had given him, 'I have sweat very much,' says the sick man. 'That is good,' says the physician; another time, having asked him how he felt after his physick, 'I have been very cold and have had a great shivering upon me,' said he. "That is good," replied the physician. After the third potion he asked him again how he did, "Why, I find myself swelled and puffed," said he, 'as if I had a dropsie.' 'That is very well,' said the physician. One of his servants coming presently after to inquire how he felt himself. 'Truly, friend,' said he, 'with being too well, I am about to die.'"

And so on. In this archaic atmosphere one might close his eyes and almost see old Socrates, pausing in the midst of his interminable interrogatories on some Athenian street corner to hail a passing medical man, as for instance: "But now, O Aesculapian, I am told you have planted so-and-so. I wish you would drop around to my house and see what you can do for Zantippe." Nota bene: We should strongly advise the reader to get Prof. Dowden's book on Montaigne. It will give him solace and comfort through many a long evening.—The Med. Times.

WHEN A MAN SHOULD RETIRE.

Let the reader feel no alarm. However our cotemporaries may misbehave in this regard, we shall never again resurrect that useless-at-forty—chloroform-at-sixty, episode of the recent Ewigkeit. The observations which follow are occasioned by the opinion of Prof. Chiene of Edinburgh, that there is only one sign when a man should retire—when he refuses to allow any one to help him on with his coat.

There are, in fact, other signs, but they are all to the same purport. For instance, the friend of your youth, your college chum, perhaps, has always called you dear old boy; or by some such phrase; but when he begins to change this salutation to "now, young feller," or the like, it is well for you to look in the mirror for crow's feet and to contem-

plate the graying process that seems in a most brutal and uncalled-for way to be going on about your temples. A like stage is reached when the youth of one's acquaintance speak of him as the old man. Then comes the time for sensible introspection; to care for the body more than was one's wont—more hours for sleep, less exposure to the elements, warm and well-clad feet, a little indiscretion heretofore harmless curtailed.

The question of the time to retire is largely involved in the sentiment, "other times, other manners." It would seem that in the present day no one wants to retire; that one dares not to retire, dreading the loneliness and the dreariness that must follow upon lack of the occupation to which one has been wont. An example to this effect is that an aged man who recently died after an illness of seven days. Having caught a severe cold, he persisted, despite the advice of his physicians, in going downtown to business. He would not give up his work, declaring that an old horse that once lies down never gets up. Presently he had to go to bed through sheer exhaustion, and died of pneumonia, when he might otherwise have recovered from his slight initial cold. The reason for much of this determination not to retire is the lack of other resources within one's self than that of the chief occupation in one's life. The man who has no other occupation in life than that of his business or calling—no taste for reading, no love of music or of the arts, no fad or hobby of any kind—is indeed like to have a sad and dreary old age.

We deplore here the absence of the manners and the theory of another time not so very long ago. Our meaning is emplified (though imperfectly, as shall be seen) in the life of the venerable Senator Morrill, from a New England State. It was, in early life, his ambition, as was that of his friends and neighbors, to accomplish his life work before his forty-fifth year, to accumulate before that time a competence—not many useless millions, but sufficient and adequate for the wholesome needs of a cultivated gentleman. It was his ambition, then, after his forty-fifth year to be able to devote the remainder of his life to the development of his intellect and of his tastes, to take satisfaction in the pleasure he could afford his family, to enjoy his peaceful home. It is an odd commentary upon the way in which a man is often enslaved by his environment that, having in obedience to his electorate become a United States Senator, he spent the remainder of a very long life not in the way he had designed, but in the very busy and exacting service of his countrymen.

We have certainly written thus far in vain if we cannot induce our colleagues (and Dr. Holmes,) to dip into The Autocrat of the Breakfast Table, about the middle of the book, beginning with Incipit Allegoria Senectutis.—Med. Times.

THE HEROISMS OF MEDICAL MEN.

In a consideration of this grateful theme, one is never at a loss for examples; indeed, such are so numerous that it is impossible for the most voluminous journal to accord them all their just due. We can here but consider types:

In June of this year Professor Mikulicz-Radecki died in Breslau. Obscure symptoms had given him uneasiness for some months, when early in December of last year, he discovered a hard mass in the epigastrium. In order not to mar his family's enjoyment of the holidays. he said nothing about his condition until after Christmas. And in January, at an exploratory laparotomy it was discovered that the pylorus was involved in a malignant growth so adherent to the parts adjacent as to be inoperable. He accepted the verdict with noble fortitude, and caused the report to be circulated that the operation had been done for the relief of an umbilical hernia. He resumed the full routine of his professional and clinical work until in April, after a severe hematemesis, he had to give up. He then became progressively weaker until his death. "It was a tragic perversity of fate to decree," that so great a contributor to the surgery of the stomach should himself fall victim to a carcinoma that upon diagnosis was found to be too far advanced for operation.

Dr. C. M. Shanely, of New Orleans, is reported by the New York Tribune, to be critically ill of yellow fever, "his death being expected at any moment." This physician has been in charge of the fever situation in the Barataria district. In the annals of this year's visitation of the plague, there will be recorded many instances of forgetting self amid the general desolation in fever-ridden spots, and of thinking and doing only for those in distress. Few incidents will, however, stand out more conspicuously on the page of yellow fever history than the work of this physician and his untiring devotion to a stricken people's cause. In August, Dr. Shanely, living with his wife and children on a plantation, at Barataria, volunteered to assist Dr. Brady in handling the yellow fever situation that had developed in the lake and bayou section of that parish. Though unacclimated, being a native of South Dakota, Dr. Shanely plunged into the work. Neither was he nor any member of his family immune. His field of labor was a veritable nest of infection among fishing camps; here he helped the afflicted, screened sick-rooms, gave medicines and nursed fever patients until he was himself prostrated by the infection.

Dr. Albert B. Craig, a collaborator and subeditor of American Medicine, has in his noble death given a most touching example of the physician's consecration to his high calling. Summoned to the bedside of a sufferer from fulminant cerebrospinal meningitis, his sym-

pathies aroused by the absence of all friends, and the serious condition of the patient—he gave himself literally night and day in the patient's service. "The loss of sleep, the mental strain, the extraordinary fatigue, with the exposure to infection, constituted a risk of which he was fully conscious. Upon the onset of his symptoms, he diagnosed his own case, bravely set his affairs in order, prepared his bride of but five months for the probable end, and to the last moment of consciousness, comforted her for her trial. His words, "I am neither ashamed nor afraid to die," contain the essence of what is noblest in our profession, and are a worthy epitaph to this latest of our medical heroes. "One such sacrifice does more for his chosen profession than hundreds of learned polemics. Though all too short, his life was glorious in its fulfilments." Thus states Dr. Gould, in an affectionate eulogy.

Dr. Thomas J. Barnardo, a sufferer from angina pectoris, died in London on September 19, last. He was born in Ireland and studied medicine in London, Edinburgh and Paris. While a student in London, his attention and compassion were excited by the woeful condition of destitute orphan children, for whom, on his own responsibility. he opened in 1867, a small house in Stepney causeway. From this slight beginning was developed a system by which many thousand offspring of the submerged tenth were rescued from misery and crime, and were converted into useful and reputable citizens. The success of his initial enterprise encouraged repetition, and new centres of refuge were established in different districts, until Barnardo homes are now, to the number of nearly one hundred, distributed throughout London, the principal English counties, Jersy, and Canada. There are also many mission branches. In 1873, he founded his village for girls at Ilford, in Essex, where there were fifty-two cottages, each with its family of girls, under the supervision and guidance of a mother. From year to year, these and other philanthropic enterprises have grown. The name of Barnardo is a household word throughout Great Britain. Sixty thousand waifs have been rescued, trained and started upon honorable careers through his instrumentality, of whom one-fourth have found their way to Canada and other English colonies as thriving emigrants. A year ago, when Dr. Barnardo's affection became known, and that he could no longer stand the strain imposed by his various philanthropic activities, a public meeting was held, attended by many eminent men in all walks of life, when arrangements were made for the perpetuation of the doctor's beneficent institutions. Few men have left the world, bequeathing a nobler record of wise, fruitful and self-sacrificing benevolence.—Ed. Med. Times.

IS TYPHOID CONTAGIOUS?

A correspondent calls our attention to an editorial in the Grand Rapids Herald with the above caption and to the important difference between its teaching and that of former days in regard to the contagiousness of typhoid fever. According to this editorial, Dr. Vaughan of Ann Arbor and others have advanced the idea that typhoid fever is communicated largely by personal contact. Dr. Vaughan is quoted as having made this statement: "I formerly held the view that 95 per cent. of the typhoid fever was transmitted by drinking water . . . but the experiences and information collected by the commission (appointed by the Secretary of War to study the origin and spread of typhoid in the military camps during the Spanish-American war) led me radically to change my views. I believe now that the spread was largely by personal contact. From the observations made, I reached the conclusion that under the conditions maintaining in military camps, personal contact was responsible for the spread of the disease in about 66 per cent. of the cases."

The view here announced is in harmony with recent knowledge in regard to the elimination and spread of the typhoid bacillus and the communicability of typhoid fever. The commission just mentioned rendered a most valuable service in calling attention to the ease with which typhoid fever may be disseminated by other means than infection of water, which, nevertheless, remains the most common origin of sudden, ordinary epidemic outbreaks of the disease. The report of this commission has been published and should be studied carefully by all that are interested in preventing typhoid fever.

Now, the contagiousness of typhoid fever is not to be so understood that the mere presence only of a susceptible person in the vicinity of a typhoid fever patient is dangerous. We know that typhoid bacilli are eliminated from typhoid patients by way of the feces in all cases, by the urine in a large percentage of the cases (at least 25 per cent.), and occasionally by the sputum. Contamination of the surface of the patient himself and of his immediate surroundings, consequently, is practically unavoidable. When little care is used there is the greatest opportunity for wide dissemination of the bacilli by contact. We know that flies may convey the bacilli and deposit them on various substances, including food and drink, in which the germs may multiply. "Fingers, food and flies are the chief means of local propagation. It is impossible for a nurse to avoid finger contamination" (Osler). All hospitals have "house" infections of typhoid fever in physicians, nurses, orderlies, laundry employes, etc., in spite of special precautions, and not a few deaths among house officers have resulted from typhoid so contracted.

It is unquestionably becoming recognized more and more that contact infection is an important means of spreading typhoid fever wherever it breaks out. Thus, Newman, in London, lays great stress on direct infection, the importance of which is emphasized also by F. Klemperer in Berlin. In country communities the spread of the disease when once introduced is often explainable in no other way because here we can not always fall back on a common water or milk supply, and country physicians would do well in publishing observations in point.

In view of the comparative ease with which contact infection may take place, it is rather strange that the doctrine denying case to case contagion should have survived so long. Undoubtedly, this is due to the fact that all the possibilities of direct and indirect contact infection could be fully recognized only as the bacteriology of the disease became fully understood, and much of our knowledge concerning the elimination of typhoid bacilli, their viability outside the body, their conveyance by flies, etc., is recent.

The practitioner should base his prevention of typhoid fever on the fact that it is caused by the typhoid bacillus and that this is eliminated in virulent condition from all typhoid patients in such manner and number as easily to cause infection by contact as well as through water supply. On this account, it is clear that cases of typhoid fever, in the hospital as well as in the home, should be segregated carefully until such time as neither feces nor urine contain bacilli.—J. A. M. A.

REMARKS ON THE TREATMENT OF CERTAIN AFFECTION INTERESTING BOTH PHYSICIAN AND SURGEON; TUMORS OF THE BREAST, MOVABLE KIDNEY, FRACTURES OF THE PATELLA, FLAT FEET, ECTOPIC PREGNANCY, CIRRHOSIS OF THE LIVER WITH ASCITES AND ENLARGED PROSTATE.

Clarence A. McWilliams, in discussing tumors of the breast, says that they should always be looked upon with the greatest suspicion, for eighty-five per cent. of all such growths are malignant. The operation recommended consists in the removal of the entire breast, the excision of the skin going wide of the growth, both pectoral muscles, and the lymphatics and fatty tissues of the axilla. In one hundred operations for cancer of the breast at the Presbyterian Hospital there were four deaths as the immediate consequence of the operation. At the end of three years there was no recurrence in 34 per cent. of the cases. Movable kidney is usually amenable to treatment by non-operative means, and of these the author has found Gallant's corset very useful. For fractures of the patella the author's practice is to oper-

ate openly in almost all cases where age or some constitutional dyscrasia do not contraindicate, provided there be considerable separation of the fragment, i. e. one-half inch or more. He does not operate in simple fracture of the patella until at least five days have elapsed after the injury, because infection has been shown to be eight times more liable to occur if the operation be done immediately after the injury, when one must deal with inflamed tissues, than if one operates at an interval when processes of repair are well established. If a patient complains of rheumatism of the feet, the following conditions should be kept in mind while making an exact and careful examination: Flat feet, including the weak foot, anterior metatarsalgia or Morton's toe, gonorrheal arthritis or periarthritis, tuberculosis of the ankle or tarsus, the result either of an old fracture or sprain of the tarsus, tabes, etc. The treatment of flat foot is given in detail, and is said to afford almost certain cure. The differential diagnosis of ectopic pregnancy is dwelt upon, and if Talma's operation the author says it promises well if done sufficiently early and the viscera are in fairly good condition. In considering the question of prostatic hypertrophy he says that in general operation is called for only when palliative treatment is a failure. If the symptoms grow constantly worse, if the suffering becomes severe, if the patient cannot urinate without the use of an instrument, if catheterization is painful or impossible, if the patient is too ignorant or careless to trust with a catheter, if only a catheter of very small size can be introduced, if attacks of obstinate retention occur, if there are signs of beginning infection of the kidney, if the residual urine gradually increases in amount, and if stone be present, the bladder should be opened. The perinal operation of Young is preferred.—Medical Record, December 16, 1905.

INHIBITORY AND ANESTHETIC PROPERTIES OF MAGNESIUM SALTS.

S. J. Meltzer reports the results of a number of experiments conducted by himself and John Auer during some months past at the Rockefeller Institute. Of the four main inorganic constituents of the animal body—sodium, potassium, calcium, and magnesium—the effects upon nerve and muscle of only the first three have been very carefully studied, those of magnesium for some reason having hardly been considered at all. In studying the action of various substances injected into the brain Meltzer found that magnesium produced paralysis rather than convulsions. Pursuing this lead, he found that this element with its salts invariably caused depression or inhibition of nervous and muscular action. In a few seconds after the injection

of a small dose of the sulphate or the chloride of magnesium respiration ceased and the animal would die without the struggle of asphyxia and without any sign of sensation unless artificial respiration was practiced for a long time. When injected rapidly, 0.1 of magnesium sulphate is profoundly toxic, but as much as 1.5 of the salt, if injected slowly in the course of an hour, will occasion no untoward symptoms. Herein is the probable explanation of the fact that Epsom salt, when taken in the ordinary way, produces no poisonous symptoms; some absorption doubtless occurs, but it occurs so slowly as to be harmless. In another series of experiments it was ascertained that solutions of magnesium salts applied directly to a nerve trunk caused a complete block, abolishing conduction entirely. In a third series it was found that by means of subcutaneous injection of magnesium salts complete general anesthesia, with perfect relaxation of the muscles, but without impairment of the vital reflexes, was produced. In a fourth series of experiments the magnesium salts were injected into the subarachnoid space of the spinal cord, mostly by lumbar puncture. Monkeys were the animals experimented upon. The injection of magnesium sulphate in a dose of about 0.06 per kilo of the animal's weight caused within a minute or two complete anesthesia and paralysis of the tail and hind legs. This discovery has been put to practical use in twenty operations performed under the influence of intraspinal injection of magnesium sulphate. The highest dose employed was 0.2 per kilo, or 15 drops of a 25 per cent, solution for each 20 pounds of body weight. In the first eight cases some chloroform was used to supplement the effect, as the tentative doses of the salt were very small, but in the last four the magnesium alone sufficed. The best time for operating was found to be three or four hours after the spinal injection. As a precautionary measure the author insists that the Fell-O'Dwyer apparatus for artifical respiration be on hand whenever this magnesium anesthesia is employed. Finally Meltez reports the cure of a case of tetanus at Roosevelt Hospital. After the employment of 115 c. c. of tetanus antitoxin without effect, the first injection of a solution of magnesium sulphate afforded great relief for thirty-six hours, and after a few more injections the patient was pronounced cured.—Medical Record, December 16, 1905.

THE TREATMENT OF BRONCHOPNEUMONIA.

Samuel A. Visanska says that the first requisite is to get the confidence of the family. Abundant fresh air must be secured by having the windows opened above and below, and if possible an apartment with a fireplace should be chosen as the sick room. Of the many external applications recommended he prefers the hot mustard bath.

The child should remain in it till there is a pink glow over the body, and should then be wrapped in a blanket and placed in bed, when, as a rule, it falls asleep. At the same time the high nervous tension is relieved, the child breathes more easily, the pulse is not so rapid, the capillaries dilate, and the little patient often breaks out in a copious perspiration, which carries off the toxins, thereby throwing less work on the heart, kidneys, and intestinal canal. These baths should be repeated as often as necessary. Hot camphorated oil, with mustard rubbed into the chest, is an efficient application if pleurisy is a prominent symptom. Several prescriptions for cough mixtures are given. Whiskey and strychnine are the two preferable stimulants, and when the pulse is above 130 tincture of digitalis is used, which has proved very valuable in the author's experience. It is advisable not to give the patient any water for several minutes after swallowing the dose of digitalis, which may be administered in a few drops of syrup, as water precipitates digitoxin. If the child is not breast-fed, broth, beef, milk, and egg albumen will constitute the principal articles of diet.—Medical Record, December 16, 1905.

MONSTER OF SEVENTH MONTHS REMOVED BY HYSTERECTOMY.

Dr. H. MacNaughton-Jones (Journal of Obst. and Gyn. of British Empire, October, 1905) relates the following interesting case report. The woman, forty-three years of age, became insane from the time she knew she was pregnant. Her father and uncle were both insane. On account of this condition and also because there was a probability of the uterus being myomatous, the author decided to interfere with pregnancy. Dilatation with Bossi's instrument seemed inadvisable, so that a hysterectomy was preferred. The pregnancy had advanced to the seventh month.

On opening the uterus a small intrauterine myomatous tumor was found near the fundus. The foetus was deformed, being a feminine pseudohermaphrodite. This is of special interest owing to the history of mental derangement in the family and the mother. The author even goes so far as to give this factor as a probable (?) cause of the malformation.

In this pathological report on the case, Dr. Cuthbert Lockyer describes the 14 inch foetus as having several facial abnormalities, such as cleft palate. The genitals showed externally a condition of male hyposapadias. Internally there were ovaries, tubes and a uterus. The vagina ended blindly.

After operation the mother's insanity greatly improved.

REPORT OF A CASE OF A FRACTURED TIBIA AND FIBULA; DELAYED UNION AND ITS TREATMENT.

L. M. Kommel's patient eight weeks after sustaining a complete fracture of the tibia and fibula showed very little evidence of any attempt at repair of the injury. The treatment instituted was the artificial production of a venous hyperemia at the point of fracture by means of the tight application of roller bandages above and below the seat of injury. The congestion of the part was allowed to continue for two hours daily. Phosphorus, gr. 1-100, in pill form, was given three times a day. This treatment was kept up for thirty days. At the end of the first two weeks the patient was encouraged to walk about with the aid of his crutches after the bandages were removed and the local congestion had disappeared. Five weeks after commencing the treatment the patient walked a mile without inconvenience, and an x-ray picture showed complete union with an abundance of callus.—Medical Record. December 16, 1905.

HOW CAN WE INCREASE LACTATION?

O. Rommel (Muenchen. med. Woch., 1905, No. 10; rev. in Centr. f. Gynaek, No. 40, 1905) gives a most encouraging report on the efforts to increase the efficiency of wet nurses at his institution in Munich. Mothers whose daily milk capacity on entering the hospital was only two hundred grammes succeeded in increasing the amount within a very short time to several litres a day. Nurses who had almost completely lost their milk later recovered the function of their breast.

In the nutrition of the nurses a varying diet should be instituted, consisting mostly of food containing albumen and sugar. Laktagol and other similar preparations to increase the quantity of milk gave only doubtful results. On the other hand massage proved a most effective agency for increasing lactation.

In the technique of infant feeding it is important to regulate the milk of the mother in accordance with the demands of the child. This is often very difficult in feeble children.

PROLONGED PREGNANCY.

Dr. Claude L. Holland, of Fairmont, W. Va. (Journal A. M. A., September 30th), gives an account of a case of pregnancy which lasted, dating from the last menstruation, 339 days; and dating from the last coition 313 days. These data seem to be well fixed. The cause attributed by him was a cranial deformity of the foetus, interfering with prompt natural delivery, the exact nature of which is not stated, though it is said that the brain was exposed, giving the suggestion of a breech presentation. It would have been interesting, he remarks, to have known how long this case would have gone had not quinine been given to cause uterine contractions.

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The Jefferson County Medical Society.

This society held its annual meeting on the evening of the 18th inst.

The retiring president read a short but very interesting report in which he showed the society to be in a prosperous condition. Among other things he called attention to the fact that this is one of the largest, if not the largest, medical societies in the country—having two hundred active members.

The president in his message directed special attention to the good fellowship which exists in this society, comparing the conditions with some other medical societies.

The editor of this journal is glad the president could make mention of good fellowship in the society. Nothing will destroy the efficiency of so large a body of medical men so quickly and effectively as the little jealousies an unprofessional bickering often witnessed among the members of our profession.

The president also called attention to the scientific papers which had been read, and said he considered the work of the past year as good as any in the history of the society. He recommended on account of the large membership and its probable increase, that the society consider in the near future the advisability of dividing the membership into sections. It is our opinion that the time has not yet come for this change, but we insist that the president should, in his selection of members to read papers, see to it that no one subject is made a hobby of, but as far as possible to arrange the subjects for discussion so that all important interests may be considered.

The annual banquet will be given by the society during the next ten days. These banquets are usually largely attended by the members and they are greatly enjoyed.

The officers elected for the ensuing year are as follows:

Dr. Lewis C. Morris, president for one year.

Dr. W. C. Gewin, vice-president for one year.

Dr. A. F. Toole, secretary and treasurer for three years.

Dr. Frank A. Lupton, censor for five years.

Dr. Morris, the new president, tendered his resignation as censor and Dr. W. M. Jordan, the retiring president, appointed Dr. J. D. Heacock as censor until the election of a successor to Dr. Morris, at the next meeting.

A resolution petitioning the legislature to establish one or more state sanitariums for the care of patients with tuberculosis was referred to the State Medical Association.

Important Resolution.

At the meeting on the 18th of the Jefferson County Medical Society, which has the largest membership of any medical society in the South, the following resolution introduced by Dr. E. H. Sholl was adopted:

"The Jefferson County Medical Society believing firmly in the epigrammatic axiom of Pasteur 'that it is in the power of man to cause

parasitic disease to disappear from the world,' desires to put itself on record again, as it has done in the past, in favor of every method of improved sanitation.

"To that end, in view of the alarming mortality from tuberculosis in Alabama and realizing that 'the health of the state is the wealth of the state,' we do hereby recommend to the general assembly of the state of Alabama the establishment at the earliest practical date of one or more sanitariums for the reception and treatment of tuberculosis patients. Practical demonstration has already proved the possibility of entire restoration to health of a large percentage of cases early received, thus vindicating its value not only in the relief of suffering, but as the practical solution of a great economic problem by the return to the active duties of life those who with their families would otherwise become dependent upon their respective communities. We would recommend that apart from financial details the carrying out of all such plans be left to the State Board of Health.

"In view of the above preamble, be it resolved, That this whole matter be referred to the Medical Association of the state of Alabama as the State Board of Health at its next meeting in Birmingham in April, 1906, for such wise and judicious action as shall best secure the end desired."

"Triste il mal oprando chi confida
che ognor star deggia il malefatto occulto." —Ariosto.

Sad indeed is the evildoer who trusts that his crime will always remain hidden. The sea has given up its dead and a criminal abortion and surgical scandal have come to light. Floating in Boston Harbor was found a dress suit case containing the torso of a young woman. Head, arms and legs were amputated close to the trunk by clean sweeping incisions, and expert disarticulations. The intestines and stomach were removed, evidently with the object of letting the body sink, but the unhappy criminal had forgotten that the lungs full of air would make it float. The uterus three months' pregnant, had been emptied, but it had also been perforated posteriorly, with resulting septic peritonitis. To remedy this the surgeon had opened the abdomen, sewed up the opening in the wound with catgut and packed gauze behind the uterus, closing the greater part of the incision with catgut stitches.

Near where the body was found there came ashore a bundle containing bloody underclothing and surgical dressings and in this bundle was a blonde woman's hair corresponding to a similar hair found on the body.

The bundle was wrapped in paper which was traced to a shop on Dalton Street in the South part of Back Bay district, and in this paper surgical gauze was there sold and delivered to a woman on the day on which the body was found.

The suit case in which the body was found was purchased on the day before the discovery, at a pawn shop and another suit case was purchased at another pawn shop near by, both being bought by a thick-set, dark man about forty years old, wearing a diamond pin.

Nothing more is known—perhaps nothing more will ever be known—but the whole affair is a fearful warning of the danger which besets medical men who wander from the narrow path.

For this is not the work of a common abortionist. It was a skilled surgeon, and one with a stout heart, who opened the abdomen, sewed up the rent in the uterus and drained the peritoneum of the septic patient. It was a good anatomist who dismembered the body. Yesterday a man of ability and promise, to-day a hunted criminal with a long term in prison hanging over him.

Curiously enough it is not the criminality of the abortion, nor even the death of the victim, which stirs the popular mind and incites the police to redoubled exertions. It is the "cutting up" of the dead body which to the people seems wicked and cruel and unpardonable.

Sad enough also is the discovery of the large number of young women who are missing from their homes in the city and from neighboring towns. The skeleton in many a family closet is disclosed by the fear that a loved one is not only dead but "cut up."

And after all the unhappy surgeon may not have been the original criminal.

How many men are called to treat patients already septic from abortion? How few take the precaution to fortify themselves by a consultation, or by notifying the medical examiner?

In a recent number we commented on the danger which physicians ran in consenting to treat such cases without counsel or legal protection. If the patient happens to die and in weakness or pity the nature of the case is concealed, the physician in charge becomes particeps criminis, or accessory after the fact. It seems likely that such is the state of things in this case.

Let us hope that the surgeon who operated to try to save the patient was not the criminal who caused the abortion, and if so that as he had the courage to do all that could be done to rescue the woman from death he will have the courage to come forward and clear himself and his profession from scandal and blame.—Annals of Gyneology and Pediatry.

Miscellaneous Notes.

We wish all our friends a merry Christmas and a happy New Year.

Dr. Jos. S. McLester has returned from a few weeks' stay in Baltimore.

Drs. J. D. S. Davis, Talley and Rogers have returned from Louisville where they attended the meeting of the Southern Surgical and Gynecological Society

Dr. Edgar A. Jones has arrived in the city from Raton, New Mexico, and will again make his residence in Birmingham. Dr. Jones has been in the far West about two years and a half for the benefit of his health. He continues to hold the improvement which he gained while in the West.

We call attention to the advertisment of Dr. Seale Harris' privats sanatorium in this issue of the journal. The sanatorium is located at Union Springs, Ala. Dr. Harris is giving special attention to the treatment of diseases of the stomach and intestinal troubles. The doctor is too well known in Alabama for us to make personal comment. He has for a number of years been one of the most earnest scientific workers in the state. His contributions have classed him with the profession in Alabama as a student of the best type, and he has received many assurances of the appreciation of the profession in other states.

At a recent meeting of the Jefferson County Medical Society Dr. L. C. Morris introduced the following resolution which was unanimously adopted:

"Whereas the lives and business interests of the citizens of our state and community have been seriously jeopardized during the summer just passed by the prevalence of yellow fever in our neighboring states of Mississippi, Florida and Louisiana;

"And whereas, through the grace of Almighty God and the effi-

cient quarantine established and maintained by our state health officer, we have been spared the disastrous effects both to life and property incident to an epidemic of that scourge; therefore, be it

"Resolved, by the Jefferson County Medical Society, that the thanks and high appreciation of this society be extended to Dr. Sanders for efficient service in preventing yellow fever, which has been at our doors, from becoming epidemic in our state; be it further

"Resolved, That these resolutions be spread upon the minutes of this society and that a copy be sent to Dr. Sanders, and that they be printed in the daily newspapers."

CIRCULATORY FAILURE; ITS NATURE AND TREATMENT.

Louis Faugeres Bishop says that while in former times the problem of failing circulation was approached purely from the point of view of the heart, in the broader view of modern medicine we speak of circulatory disease, because we know that the heart is only one element in the condition. In discussing practical points in treatment, he states that the use of vasodilators in the later stages of circulatory disease is a great error. Another is overestimating the importance of renal complications. In many cases the patient's condition does not improve until the idea of directly influencing the function of the kidneys is abandoned, and the attention is given to the circulation. Still another mistake is that of under-estimating the sluggishness of the whole organism and the resulting necessity of increasing the dosage of remedies. The author speaks especially of digitalis, strychnine, and iodide of sodium as being useful, and says that the doses of the first two must be pushed until physiological action is produced. It is also often an advantage to have the patient sit in a chair rather than stay constantly in bed.—Medical Record, December 16, 1905.

THE THERAPEUTIC VALUE OF STATIC ELECTRICITY.

May Cushman Rice in discussing this subject says that while static electricity is by no means a cure-all, it is so valuable an adjunct to other therapeutic measures that it should be better understood by the general practitioner. The positive breeze is specially useful for relieving congestion, if the positive pole is used, whereas the results are less good if the negative pole is employed. A common mistake in electrotherapeutics is not to allow sufficient time for the treatment. Less than twenty minutes is not enough, and usually one-half hour is better. Headaches, epilepsy, neurasthenia, hysteria, are all benefited

by the breeze, which is a sedative, while the static spark is a stimulant. Sparks produce counterirritation and are useful in breaking up adhesions, will abort acute rheumatism, rupture ganglia, etc. Convalescence after operations or prolonged illnesses, tuberculosis, neuritis, tic douloureux, and constipation are other conditions for which the author recommends the use of static electricity in one form or another.—Medical Record, December 16, 1905.

THE TREATMENT OF CHRONIC CONSTIPATION.

J. A. Macmillan has found the use of rectal tampons a very valuable plan of treatment in chronic constipation of the atonic variety. The tampon is made of absorbent cotton, cheese cloth, or lamb's wool, and should be sufficiently large to cause some distention of the bowel. It can be inserted through an ordinary proctoscope and packed into place by means of a long forceps. The best results are obtained when it is placed at the rectosigmoidal junction. The tampon is provided with a piece of string to facilitate withdrawal at the end of from two to six hours. At first the tampon is used every other day, and the interval between treatments is gradually lengthened as improvement follows. The author ascribes the value of the measure to the distention of the intestine caused by it. He has been successful in most cases in which he has tried it, though a few failures are noted. In a large proportion of cases enemata and cathartics may be discontinued from the first, and regularity in the passage of normal stools soon begins to be reinstated.—Medical Record, December 16, 1905.

THE DIAGNOSIS AND TREATMENT OF RENAL TUBERCULOSIS.

In these days of indiscriminate surgery, when the advent of asepsis allows and encourages the use of the knife by those who are not prepared to use it, the thinking internist is in danger of taking too conservative a view as to the necessity of operative procedures in certain classes of cases. Among the conditions which stand on debatable ground so far as operative indications are concerned, renal tuberculosis must be mentioned. There are many who believe that this condition is essentially a medical problem, and that operative treatment is to be resorted to only as a last chance, and this view

is held even by genitourinary surgeons of note. In a paper before the recent Congress on Tuberculosis, Albarran, who has certainly earned the right to speak authoritatively on this subject, discusses the problem in a very lucid manner. The decision as to whether a given condition is to be considered in the province of the physician or of the surgeon depends on a variety of circumstances. In dealing with tuberculosis in paired organs, like the kidneys, the problem is simplified by the fact that one can be removed with relative impunity provided that the other be intact. The main questions to be answered, then, are these: How frequently are the kidneys unilaterally affected in this condition? What is the usual outcome in cases treated expectantly on purely medical lines? How does the mortality under surgical treatment compare with that under medical?

These questions are taken up seriatim by Albarran, and are answered by quotations from his own statistics and from those of other observers of experience. Unilateral involvement in renal tuberculosis is the rule rather than the exception, it occurs in at least 85 per cent. of the cases, and in the majority there is no serious involvement of other organs, a point of great importance. It is true that in most cases there are symptoms which would lead the inexperienced to believe that the bladder also is infected, but the use of the cystoscope has shown conclusively that, at any rate early in the disease, the bladder lesion is of an irritative character, and is not a true cystitis. Even when signs of early lung involvement are present, a not unusual complication, experience has shown that operative intervention is rather of benefit than otherwise. The history of these cases under medical treatment is far from encouraging. Spontaneous healing is known, but is rare, and when it occurs is always due to the blocking of the ureter by the inflammatory process, a condition which throws the affected kidney out of function just as effectively as surgical removal, but is less satisfactory than the latter procedure on account of the length of time it consumes and the fact that it still leaves in the body a latent focus of disease which at any time, even years after the ureteral blocking, may again become active and cause the death of the patient. In most cases the progress under medical treatment is a slow but a steady downhill progression. Tuberculosis of the bladder, with its long-drawn agony, is followed by ascending

infection of the sound kidney, or generalization of the disease, and the patient dies a lingering and painful death. In competent hands, the removal of the kidney is in itself an operation with slight mortality. Albarran lost but 3 per cent. of his cases, and the combined mortality of the six operators who have reported the largest series of cases totals 7 per cent. This is certainly a vast improvement over the mortality under medical treatment.

As in other conditions in which surgical intervention is of aid, its value often depends, in part at least, on the early recognition of the disease. This means that the general practitioner must learn to recognize, or at any rate to suspect, the presence of this condition at an early date. The specialist has at its command methods of diagnosis which, of necessity, are not available to the average physician. Catheterization of the ureters, of which the genitourinary surgeon speaks so glibly, is an operation requiring a good deal of skill, a large amount of experience, expensive instruments, and an amount of time which the ordinary physician does not possess. Yet it is the procedure par excellence in the diagnosis of early kidney tuberculosis. The practitioner must rely on other and more common methods of observation, and Albarran briefly sketches what he considers the more important of these. The history of vesical irritation, with more or less pain on urination, and the passage of a pale, slightly cloudy urine, is of importance. If a definite cystitis is present its occurrence without definite cause, its aggravation under local treatment, and the absence of the ordinary micro-organisms from the urine are all suspicious circumstances. Attacks of spontaneous hematuria should be looked at askance, especially if they are not modified with rest, are painless, or are at most accompanied by vague painful sensations in the region of the kidneys. Naturally an examination of the urine for tubercle bacilli is called for, and it is to be remembered that the fresher the specimen the better the chance of finding the bacilli. The finer methods of diagnosis must often be left to the specialist. Early diagnosis is the key to success.—J. A. M. A.

THE TREATMENT OF DIARRHOEA IN INFANCY AND CHILDHOOD.

This appeals most strongly to those who are interested in the care of children, especially at the advent of the summer months when the mortality from this malady is more than one-half of those who die under twelve months of age. Two forms of acute diarrhoeas are recognized, one of a simple nature due to the presence in the intestinal tract of some form of food, or a surplus of food, which the child can not digest, the other an infectious diarrhoea in which pathogenic bacteria are present. The dysentery bacillus was isolated by Shiga in Japan in 1898, and following up this announcement, Flexner and his co-workers, at the Rockefeller Institute in 1903, found a bicillus agreeing in all essential points with the Shiga bacillus dysenterrae. These with various streptococci and other pus forming micro-organisms are the pathogenic agent to which the infectious, or "summer diarrhoea" of children is due.

Since only a bacteriological examination will determine at the onset of an acute diarrhoea whether it is of a simple or an infectious nature, such treatment must be inaugurated as will meet either indication.

Much can be accomplished in the way of prophylaxis. Since these troubles are more prevalent in the hot months of the year, and in the more crowded and unsanitary sections of the larger towns, a temporary change of residence to the mountains or the country is to be advocated for those who can avail themselves of such a change. When not available all should be done to make the home surroundings conducive to the child's comfort. The largest, coolest and airiest room should be for the children. The clothing should be only sufficient to protect the body from sudden changes or exposure and to keep it comfortable. All the water given to the infant, and this need not be sparing, should be previously boiled and cooled. If the child is artificially fed the milk and milk foods must be pure and fresh and all vessels and utensils used in dispensing, thoroughly and frequently sterilized.

A beginning diarrhoea should always arouse suspicion, and for twenty-four hours all milk and food should be withheld. Milk is absolutely contra-indicated, and under no circumstances must it be

allowed. Plain boiled water may be given if there is much thirst, and when the child is very hungry, albumen water, barly water or whey, may be allowed. If the diarrhoea is simple in nature a mild cathartic, preferably calomel in half-grain doses, followed by castor oil will remove the offending material, and this in all probability will be all the treatment required. Gradually the ordinary regime can be resumed and the child by degrees returned to the breast or milk diet.

The infectious form of diarrhoea occurs more frequently among bottle-fed babies, and ninety-seven per cent. of those who succumb to this form of the disease are fed artificially. Here, as in the simple diarrhoea, the milk either from the breast or cow should be discontinued and for twenty-four hours no food of any character must be given, unless it be albumen water. A baby can be kept for days upon this mixture without danger of reducing the strength. The white of one egg is equal in nutritive value to three ounces of breast milk. A cathartic at the outset is indicated and calomel and castor oil answer every indication. For the vomiting, and this rarely persists after the food is stopped, small doses of calomel, one-twentieth of a grain every fifteen minutes, is usually given. If it still persists, the stomach must be washed out, and usually after one irrigation there is no more trouble. Irrigation of the colon is advisable in all cases, as it hastens the action of the cathartic and removes the irritating and offending material. This should be done twice a day—a saline solution of physiological strength and a fountain syringe with soft rectal tube being preferred. Drugs are secondary importance when compared with dietetics. Certain drugs that are classed as astringents and antiseptics are frequently used and much vaunted, but their efficacy is disputed. Of these perhaps the most valuable are bismuth and salol, and when combined in a pleasant vehicle may be given with benefit every few hours. When there are indications of collapse and rapid prostration, as in cholera infantum, the injection under the skin of a normal salt solution is indicated in small amounts for the operation is painful.

Too much treatment does more harm than good in these cases. It is a mistake to be putting too many drugs and foods into an irritable, nauseated stomach. Hours of rest do more good than hours

of treatment. No food, fresh air, pure water, and a minimum of medicine are the cardinal points in treatment.—Southern Medicine and Surgery.

MORTALITY OF CONTRACTED PELVIS IN THE PAST AND THE PRESENT.

Baisch (Centralblatt f. Gyn., 1905, No. 41, page 1,244) cites the remarkable fact that with the decrease of foetal mortality in the treatment of contracted pelvis from 16.8 to 6.6 per cent. there has been likewise a decrease in maternal mortality from 5 per cent. to 0.1 per cent. Searching for the cause of this decrease he finds that abandonment of prophylactic version has given better results. The cause of death among the children is in the first place version on account of transverse position or prolapse of the cord; secondly, through waiting for spontaneous birth; and finally directly from the results of the high forceps. Baisch concludes:

(1) In the transverse position external version to bring down the head should be resorted to wherever possible.

(2) Expectative procedures should be shortened in prolonged labor by operative measures, usually forceps.

(3) High forceps and prophylactic version are contraindicated where the head has not entered the pelvis.

CATARRH OF BLADDER IN PULMONARY TUBERCULOSIS.

Campani (Gazetta degli Ospedali, Milan, xxvi., No. 82) has noticed symptoms of catarrh of the bladder in a number of cases of early tuberculosis. He presents arguments to prove that this catarrhal condition of the bladder is the result of the lesser acidity of the urine in the pretuberculous stage and in incipient tuberculosis. This harmonizes with the views recently advanced by some writers that hypoacidity is an accompaniment of and favors the development of tuberculosis, and accompanies it in its early stages. The hypoacidity further favors the development of pseudo-phosphaturia and cystitis, and is a depressing element for the organism in general. Alkalines should not be administered to such patients, and their diet should be regulated to prevent the possibility of "alkaline cachexia," excluding more or less the starches and vegetables.

ROENTGEN TREATMENT OF HYPERTROPHIED PROSTATE.

Moszkowics (Muenchener Med. Wochenschrift, Munich, lli., No. 29), has already reported three cases of enlarged prostate treated by application of the Roentgen rays through the rectum. He here continues his reports with six new cases. Unmistakable benefit was derived in every instance. The effect was most rapid and pronounced in the cases in which the anuria was of recent occurrence. The gratifying results and the harmlessness of the procedure commend it for extensive application, possibly supplemented by the action of radium in the urethra. In all the cases three sittings of from 10 to 18 minutes each had a pronounced influence on the enlarged organ and on the symptoms. The prostate subsided in size and micturition became more or less normal. In three of the cases the patients exhibited symptoms of arterio-sclerosis, with indications of angina pectoris.

F. P. Kimmicutt (Medical Record, June 10, 1905) in a "contribution to Hemophilia" gives the following summary: (1) The interual administration of the lime salts, especially of the chloride of calcium, in doses of two grammes (30 grains) twice or thrice daily. Its continued use should be interrupted every two or three days by a period of twenty-four hours. (2) The application of solutions of the same salt with compression, for accessible surface bleedings. Aqueous solutions of one-half per cent. are efficient. Another convenient mode of employment is in the form of a finely powdered chalk mixed with one-half per cent. solution of the calcium chloride. The less soluble lime salts, such as calcium phosphate, are equally efficient for local application. (3) The use of a combination of one-half per cent. solution of calcium chloride and one-sixth volume of a solution of nucleoalbumin for local application. The nucleoalbumin can be obtained from aqueous extracts of various cellular tissues—testicle, thymus, thyroid, ovary, etc. If the prepared extracts are not available, a supply may be procured readily by mincing any of these tissues in a weak alkaline solution (1:500 solution carbonate of sodium), and filtering through gauze after a few minutes. (4) The application of a stream of carbonic acid gas to the bleeding surface, in accessible hemorrhage; its inhalation, freely mixed with ordinary air or oxygen, in concealed hemorrhage. (5) The use of four-per-cent. solution of chloral hydrate for surface bleeding, and also of adrenalin (1:1000), with compression.

Guy C. Kinnaman (Journal A. M. A., August 26th, and September 2d), after a long series of painstaking experiments, reaches the following conclusions concerning the antiseptic power of iodin:

1. In a solution of iodin, varying from a 0.2 per cent. to a 1 per cent., we have a germicidal agent of very marked potency.

2. Its germicidal power is far superior to that of bichlorid of mercury, the acknowledged leader of all other antiseptics. This fact was shown by experiments made with a 1-1000 solution of bichlorid of mercury on Streptococcus pyogenes, using the same method employed with iodin solution. It was found that an exposure of fifteen minutes, although showing considerable inhibitory power, especially on the first day, permitted a good growth of streptococci to appear. An exposure of thirty minutes gave no growth. The superiority of iodine is readily evidenced by recalling the fact that a comparatively weak solution of iodin, i. e., 0.2 per cent., gave death after two minutes' exposure.

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3. It approaches nearly to the ideal antiseptic in that:

(a) It is easily prepared and is stable.

(b) It is non-toxic and non-irritating in strength effective, being only one-fourth as toxic as bichlorid of mercury.

(c) It does not coagulate albumin or form inert compounds with tissues.

(d) It is effective in a very brief time.

(e) The stain it produces soon disappears.

(f) Lastly, and most important, it possesses a remarkable penetrating power.

4. In conclusion, it is well to state that an 0.5 per cent. solution is amply strong enough for all practical usage.

MEDICAL PAPERS AND PROPRIETARY MEDICINES.

Our contemporary, The Journal of the American Medical Association, is not having by any means an easy task in its attempt to enlighten the physicians of the states on various points regarding the trade in proprietary articles. Many of the proprietors of much-advertised preparations regard the undertaking as a direct attack on their trade, and they are ready to use any weapon in self-defense.

In particular, many of the less important medical papers, whose existence depends in great part on the returns from their advertisement columns, have published violent attacks on The Journal and on the personality of its editor. In some cases these attacks are little else than paraphrases of the matter to be found in the advertising columns of the same papers. How strong a hold some of these manufacturing druggists have over the medical press in America is shown in an amusing way by a letter to The Journal itself from the proprietors of a much-vaunted hematinic, many of whose advertisements are doubtless at present in our readers' waste-paper baskets. In an editorial article in our contemporary some months ago, the statement occurred that "the day of blind reliance on iron, quinin, and tonics in general in the treatment of anemic conditions in tropical countries is past, never to return." This seemingly innocent remark drew forth an indignant letter of remonstrance from the proprietors of the hematinic, who regard it as a direct "slap in the face," since it is alleged to cast a slight on their preparation, and they threaten in consequence to withdraw their advertisement. When an attempt is made to restrain such a paper as The Journal of the American Medical Association from free comment, one may judge the freedom permitted to less independent and less scrupulous journals.—Medical Press and Circular, London.

INDICATIONS FOR HYSTERECTOMY IN PUERPERAL SEPTICEMIA.

Dr. C. G. Cumston read a paper on this subject at the last meeting of the American Association of Obstetricians and Gynecologists.

He states that hysterectomy applied to the treatment of puerperal infection is as yet a mooted question, as far as its indications are concerned, and it would be quite illogical to advise this interference in all serious cases, as it would be systematically to condemn it. All surgeons seem to be in accord as to the great difficulty of formulating the indications for this operation, and especially the time when these become formal. To come to a conclusion, all clinical methods of examination and those of the laboratory

must be employed. The latter, however, are far from being of equal value, as no positive result can be obtained from a bacteriological examination of the lochia or blood. Cytologic examination of the blood will give excellent data as far as the prognosis of the type of infection is concerned. Clinically, there is no one valuable sign, but, taken together, the symptoms obtained by careful intrauterine examination may indicate the necessity of surgical intervention when all other therapeutic measures have failed. Septicemia occurring at once after labor cannot derive benefit from surgery, but, on the other hand it will appear that histerectomy is indicated in cases of secondary septicemia with a slow evolution, or those taking on a pyemic type, proceeding by successive stages, on the condition that there are no visceral metastases, in which case surgical treatment would be a method of exception.—Reports of Amer. Med. Journal.

GUN-SHOT FRACTURES OF THE SKULL IN THE RUSSO-JAPANESE WAR.

M. I. Glagolyev in Chirurgia (Moscow and St. Petersburg) reports ten selected cases, and from his observations concludes:

1. In gun-shot "contact fractures," of the skull it is difficult to determine the extent of injury by ordinary means (inspection, palpation and probing).

2. When a bullet acts on the skull by contact there may be a fracture of the external plate only or of both plates.

3. Between the depressed external plate and the uninjured internal plate foreign bodies may at times be found.

4. In gun-shot "contact fractures" of the skull, we may find torn dura and destroyed portions of brain substance without the presence of abnormal manifestations either psychical, motor or sensory. On the other hand we may have cases in which even the dura is uninjured and yet manifestations of focal injury to the brain are present.

5. In some cases with suppuration of the wounds of the soft parts we find suppuration of brain wound also, but this is determined only by operation.

6. Suppurating wounds of the brain may not cause any rise in temperature even if the pus is under pressure.

7. It is difficult to decide before operation whether dura or brain substance is injured and whether there is suppuration of the brain substance or not.

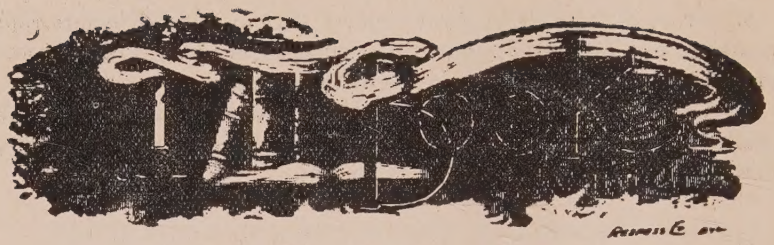
8. From the above Glagolyev deduces that in order to insure rapid recovery and prevent complications, such as meningitis and abscess of the brain, operative measures are indicated.

9. Conservative treatment of infected gun-shot fractures of the skull is fraught with danger to the patient's life. In support of this Glagolyev reports a case thus treated.

THE PROBLEM OF PREVENTING TUBERCULOSIS.

McFarland regards this as the greatest of all problems, especially since ten millions of the present population are likely to die from the disease, either directly or indirectly. It is a disease common to man and animals, and the sequence of the bacillus of Koch. Whether there are various tubercle bacilli peculiar to different animals is undecided. When an infectious agent passes from man to man in the morbid discharges, in the majority of cases it is from the respiratory apparatus. It may be projected into the atmosphere by cough for several metres and remain suspended a long time. Infection may be derived from animals and from such food products as meat, milk, butter, cheese, etc. Rarely the disease is transmitted from mother to offspring by the placenta; occasionally by coitus when the reproductive organs are diseased. The most frequent avenues are: (1) The skin, by careless contact with infectious material; (2) the respiratory tract into which it may be inhaled; (3) the digestive tract into which it may be swallowed. The first manifestations of the disease are not necessarily in the part of the body into which the bacilli may have been introduced. Preventive measures consist (1) in the protection of the well, (2) in the care of the ill. Instruction of school children, in as simple a manner as possible, concerning the importance of the subject is advised, and adults should be instructed by pamphlets, lectures, newspaper articles, and personal advice from physicians. Suitable legislative measures should be enacted concerning the construction and care of tenements, workshops, public vehicles, and foods. The proper inspection of meat and milk is of the greatest importance. Those who are ill, especially those who remain at home, and are poor and ignorant, should be objects of especial concern and care, on account of others not less than on their own account. Such patients should have done for them by public authorities, in food, clothing, medicine, and in general sanitary care what they can not for themselves.—Medicine, August, 1905.

The painfulness of withdrawing packings that have dried in a wound may be avoided by soaking them with peroxide of hydrogen.—American Journal of Surgery.



A MANUAL OF DISEASES OF INFANTS AND CHILDREN. By John Ruhrah, M. D. Clinical Professor of Diseases of Children, College of Physicians and Surgeons, Baltimore. 12mo volume of 404 pages, fully illustrated. Philadelphia and London: W. B. Saunders & Company, 1905. Flexible leather, $2.00 net.

Dr. Ruhrah is to be congratulated upon the production of a manual that presents the subject of pediatrics in such a clear yet concise manner. He has outlined the therapeutics of infancy and childhood in a way that cannot fail to make for this work a place of first importance in its field. He has given explicit instructions for dosage and prescribing, and a number of useful prescriptions are appended. Infant feeding is given in detail. All the illustrations are practical, and include three inserts. A very valuable feature consists in the many references to prediatric literature so selected as to be easily accessible by the student, enabling him to ascertain the sum of knowledge on any given disease. We give Dr. Ruhrah's work our unqualified recommendation.

A TEXT-BOOK OF DISEASES OF WOMEN. By Barton Cooke Hirst, M. D., Professor of Obstetrics, University of Pennsylvania. Second edition, revised and enlarged. Octavo of 741 pages, with 701 original illustrations, many in colors. Philadelphia and London: W. B. Saunders & Company, 1905. Cloth, $5.00 net; Sheep or Half Morocco, $6.00 net.

Dr. Hirst may well be congratulated upon the publication of such a work as this, a second edition of which has just appeared. Written on the same lines as his "Text-Book of Obstetrics," to which it may be called a companion volume, it gives every promise of attaining success. The palliative treatment of diseases of women and such curative treatment as can be carried out by the general practitioner have been given special attention, enabling physicians to treat many of their patients without referring them to a specialist. Indeed, throughout the book great stress has been laid upon diagnosis and treatment, and the section devoted to a detailed description of modern gynecic opera-

tions is without doubt the most clear and concise we have yet read. In this second edition the revision has been thorough, introducing, however, only such matter that promises or has been demonstrated to be of permanent value. Forty-seven new illustrations have been added and thirty of the old ones replaced, the work now containing a collection of seven hundred and one beautiful original illustrations, many of them in colors. We take much pleasure in recommending Dr. Hirst's work to the medical profession generally.

A TREATISE ON DISEASES OF THE SKIN. For the use of advanced Students and Practitioners. By Henry W. Stelwagon, M. D., Ph. D., Professor of Dermatology, Jefferson Medical College, Philadelphia; and Clinical Professor of Dermatology, Woman's Medical College Philadelphia. Fourth Edition, Revised. Handsome octavo of 1135 pages, with 258 text-illustrations, and 32 full-page lithographic and half-tone plates. Philadelphia and London: W. B. Saunders & Company, 1905. Cloth, $6.00 net; Sheep or Half Morocco, $7.00 net.

Four large editions of Dr. Stelwagon's work have been required in three years. Surely such a sale bespeaks a book of unusual merit. Notwithstanding the frequency of editions, Dr. Stelwagon has not lost this opportunity to bring his book up to the latest knowledge. The therapeutic use of the Rontgen rays, high-frequency current, and Finsen light have been accorded the increased attention their growing importance deserves. We notice the addition of new text cuts, some thirty-eight in number, and six additional insert plates, all up to the high standard set by the text. The author, by the judicious elimination of redundant materials, has kept the size of his book much as before, the increase being only some twenty pages. Indeed, it is remarkable the epigrammatic way that Dr. Stelwagon has of saying things—a style most desirable both in text-book and a reference work for the busy practitioner.

A TEXT-BOOK OF PHYSIOLOGY: for Medical Students and Physicians. By William H. Howell, Ph. D., M. D., LL. D., Professor of Physiology, Johns Hopkins University, Baltimore. Octavo volume of 905 pages, fully illustrated. Philadelphia and London: W. B. Saunders & Company, 1905. Cloth, $4.00 net; Half Morocco, $5.00 net.

Dr. Howell's many years of experience as a teacher of physiology in several of the leading medical schools is evident throughout the entire work in the simple and clear style and in the practical handling of his subject. The author has laid main emphasis upon those facts and views which will be directly helpful in the study of general pathol-

ogy and in the practical branches of medicine. At the same time, however, we are gratified to see that Dr. Howell has not ignored the experimental side of the subject. This we consider very important, for it has been through individual research that all the great advance in physiologic knowledge has been made. The entire literature of physiology has been thoroughly digested and the important views and conclusions incorporated. Indeed, the author has prepared a text-book which, while preserving the scientific spirit, is at the same time simple and modern in presentation. Every notable advance in physics or chemistry as influencing physiology has been carefully noted. Illustrations have been most freely used, greatly helping in understanding and supplementing the descriptions in the text. Especially valuable are those illustrations employed to make clear the more intricate anatomic and physiologic mechanisms. Altogether, we consider it a very valuable book, because it is accurate, up to date, and highly practical.

SAUNDERS' POCKET MEDICAL FORMULARY. By William M. Powell, M. D., author of "Essentials of Diseases of Children;" Member of Philadelphia Pathological Society. Containing 1831 formulas from the best known authorities. With an Appendix containing Posological Table, Formulas and Doses for Hypodermic Medication, Poisons and their Antidotes, Diameters of the Female Pelvis and Fetal Head, Obstetrical Table, Diet-list, Materials and Drugs used in Antiseptic Surgery, Treatment of Asphyxia from Drowning, Surgical Remembrancer, Tables of Incompatibles, Eruptive Fevers, etc., etc. Seventh Edition, Revised. In flexible morocco, with side index, wallet, and flap. $1.75 net. Philadelphia and London: W. B. Saunders & Company, 1905.

When a work has reached its seventh edition there can be no doubt of its practical usefulness. And it is not at all surprising to us that Saunders' Pocket Medical Formulary should have attained such popularity, for we know of no similar work containing so much useful, practical, and accurate information in so small a compass. In this new seventh edition there have been added over 460 new and valuable formulas, selected from the works and private practices of the best authorities. The editor has shown rare discretion in the elimination of many obsolete formulas, inserting in their place newer and better ones, embodying a large number of approved new remedies. In its new edition this Formulary is thoroughly representative of the most recent therapeutic methods, and its convenient size and mechanical get-up make it the most desirable work of its kind on the market.